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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Edgar W. Dickson, Circuit Court Judge

Dale E. Van Slambrook, Circuit Court Judge

Jessica A. Salvini, Circuit Court Judge

Appellate Case No. Case: 2025-001304

Case No. 2021-CP-10-03379

Carolina Neurosurgery & Orthopedics, Inc.,……Appellant/Respondent

v.

Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,……Respondents /Appellants

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	IN THE NINTH UDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopedics, Inc.,	)	
	)	**ORDER ON DEFENDANTS' MOTION TO DISMISS**
Plaintiff,	)	
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	
	)	

THIS MATTER comes before the Court on Defendants' Michael A Maucher, Esq. ("Maucher") and Deluca & Maucher, LLP's ("D&M") (collectively, "Defendants") Motion to Dismiss Plaintiff's Complaint, filed October 22, 2021. The Court heard oral argument on Defendants' Motion on March 3, 2022. Thomas A. Pendarvis, Esq., appeared for Plaintiff, and Michael C. Masciale, Esq. appeared for Defendants. After carefully considering the Complaint filed in this action, memoranda filed by the parties, arguments of counsel, and the applicable law, Defendants' Motion is respectfully GRANTED in part and DENIED in part. In support of this Order, the Court finds and concludes as follows:

FINDINGS OF FACT

1. Plaintiff Carolina Neurosurgery & Orthopedics, Inc. ("Plaintiff") is a citizen and resident of Charleston County, South Carolina licensed to practice medicine in South Carolina.

2. Jason M. Highsmith, M.D. ("Highsmith") is Plaintiff's primary surgeon.

3. Maucher is a citizen and resident of Charleston County, South Carolina, and he is an attorney licensed to practice law in South Carolina.

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4. D&M is a South Carolina Limited Liability Partnership operating as a law practice with offices in Charleston County and Berkeley County, South Carolina.

5. On December 14, 2018, Defendants' client ("Client") was injured in a motor vehicle collision. Shortly thereafter, he retained Defendants to pursue claims against the at-fault driver.

6. As Client was a prior surgery patient of Plaintiff and Highsmith, he selected Plaintiff for surgical treatment of his injuries arising from the accident. Highsmith performed the procedures.

7. On December 20, 2018, at Client's request, D&M sent Plaintiff a letter of protection ("December 20, 2018 LOP"), in which D&M agreed to protect any claim by Plaintiff for the cost of Client's treatment out of any settlement proceeds arising from the accident. The December 20, 2018 LOP is attached to Plaintiff's Complaint as Exhibit 1 and is incorporated herein by reference.

8. On January 3, 2019, Client executed Plaintiff's Financial Policy ("Financial Policy"), which is attached to Plaintiff's Complaint as Exhibit 2 and is incorporated herein by reference.

9. The Financial Policy provides that Plaintiff will submit claims for payment under a patient's primary health insurance.

10. On January 16, 2019, Kiara Goodwine ("Goodwine"), an employee in Plaintiff's office, contacted D&M to request information regarding the at-fault driver's liability policy limits. On January 21, Tina Bennett, a paralegal with D&M ("Bennett") responded that the at-fault carrier was from North Carolina and would not disclose policy limits without a medical

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authorization from Client. However, Bennett informed Goodwine that Client carried a total of $1,100,000 in accident coverage under two additional insurance policies.

11. On the same day, Bennett also emailed Goodwine and informed her that based upon the severity of Client's injury and his pre-existing injuries, all of his treatment would need to be filed with his private health insurance and should not proceed under a letter of protection.

12. Goodwine acknowledged receipt of the email and Bennett's instructions. The foregoing emails are attached to Plaintiff's Complaint as Exhibits 4-5 and are incorporated herein by reference.

13. Accordingly, as of January 21, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance.

14. On March 7, 2019, D&M sent a revised letter of protection to Plaintiff ("March 7, 2019 LOP"), stating that D&M would protect whatever amounts Client's private health insurance did not pay out of the proceeds of any settlement of Client's personal injury claim.

15. Bennett's email containing the March 7, 2019 LOP stated that "[t]his LOP covers whatever is NOT paid by private health insurance." Bennett's email and the March 7, 2019 LOP are attached to Plaintiff's Complaint as Exhibit 6 and are incorporated herein by reference.

16. As of March 7, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance first before seeking payment under the March 7, 2019 LOP.

17. Despite D&M's prior instructions and the express language of the March 7, 2019 LOP, Plaintiff never attempted to confirm its network status with Client's private health insurance carrier prior to rendering surgical services, or to file claims for payment with Client's private health insurance, as is required under Plaintiff's Financial Policy.

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18. Highsmith performed Client's first surgery—a C6-7 ACDF surgery—on March 15, 2019 ("First Surgery") at a cost of $62,451.87.

19. As Client's personal injury case developed, it was determined that: (1) the at-fault driver did not have sufficient insurance coverage to fully cover Client's medical treatment; (2) one of Client's other additional policies was inapplicable; and (3) the other additional policy was subject to subrogation and only applicable after Client's primary private health insurance had been exhausted.

20. On April 29, 2019, D&M notified Plaintiff via email of the foregoing issues, stating:

> "Because the at-fault party only had $30,000.00 and [Client's] Underinsured Motorist Coverage does not apply, ALL of the treatment [Client] has received (and will continue to receive) must be filed under his private health insurance. We cannot honor anymore treatment under a Letter of Protection. Please note [Client's] file accordingly."

21. On May 2, 2019, Highsmith performed additional surgery on Client at an approximate cost of $65,000.00 ("Second Surgery").

22. Despite receiving explicit instructions regarding claim submission and payment on several occasions prior to both surgeries, Plaintiff never attempted to file claims for Client's surgical services with Client's private health insurance.

23. Instead, Plaintiff waited until around November 2, 2020—almost one year after the completion of Client's treatment—to send Client a bill for surgical services in the amount of $125,409.28. Plaintiff's bill is attached to Plaintiff's Complaint as Exhibit 3 and is incorporated herein by reference.

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24. Client has made no payments to Plaintiff for the medical and surgical services provided, and Defendants have not disbursed any funds from the $30,000.00 settlement proceeds recovered for Client.

25. Plaintiff filed this action on July 22, 2021, asserting causes of action against Defendants for: (1) Breach of Contract; (2) Breach of Contract Accompanied by a Fraudulent Act; (3) Violation of the South Carolina Unfair Trade Practices Act; (4) Fraud; (5) Constructive Fraud; (6) Unjust Enrichment; and (7) Negligence.

26. Defendants were served with process on September 24, 2021.

27. Defendants filed their Motion to Dismiss Plaintiff's Complaint on October 22, 2021.

PROCEDURAL STANDARD

When ruling on a Motion to Dismiss pursuant to Rule 12(b)(6), SCRCP, "[t]he circuit court may dismiss a claim when the defendant demonstrates the plaintiff's 'failure to state facts sufficient to constitute a cause of action' in the pleadings filed with the court." *Hambrick v. GMAC Mortg. Corp.*, 370 S.C. 118, 121, 634 S.E.2d 5, 7 (Ct. App. 2006) (*citing FOC Lawshe Ltd. P'ship v. Int' l Paper Co.*, 352 S.C. 408, 412, 574 S.E.2d 228, 230 (Ct.App.2002)). If, in viewing the complaint in the light most favorable to the plaintiff, the court determines the facts in the complaint are insufficient to entitle the plaintiff to the relief it seeks, the court should grant the motion. *Baird v. Charleston Co.*, 333 S.C. 519, 527, 511 S.E.2d, 69, 73 (1999).

CONCLUSIONS OF LAW

Based upon the foregoing, the Court makes the following Conclusions of Law:

28. The Court has jurisdiction over the subject matter of this case and the parties hereto.

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29. Venue is proper in Charleston County, South Carolina.

I. Plaintiff's Negligence Claim

30. Plaintiff's Complaint fails to allege facts sufficient to support a cause of action for Negligence against Defendants because, as a matter of law, Defendants owed no duty of care to Plaintiff.

31. To establish a cause of action for negligence, a plaintiff must show: (1) the defendant owes a duty of care to the plaintiff; (2) the defendant breached that duty by a negligent act or omission; (3) the defendant's breach was the actual and proximate cause of the plaintiff's injury; and (4) the plaintiff suffered an injury or damages. *Roddey v. Wal-Mart Stores East, LP*, 415 S.C. 580, 589, 784 S.E.2d 670, 675 (2016).

32. The existence of a legal duty is an indispensable element of Negligence. See, e.g., S.C. Elec. & Gas Co. v. Utilities Const. Co., 244 S.C. 79, 88, 135 S.E.2d 613, 617 (1964) ("The breach of a legal duty is essential to negligence…Without a violation of such a legal duty, there is no negligence.").

33. For a duty to arise in the context of an attorney's professional activity, an attorney-client relationship must generally exist between the attorney and the party asserting a claim for Negligence. *See Holy Loch Distributors, Inc. v. Hitchcock*, 340 S.C. 20, 26, 531 S.E.2d 282, 285 (2000) (stating that in a legal malpractice and negligence action, a plaintiff must establish, among other elements, "the existence of an attorney-client relationship.").

34. "Generally, "an attorney is immune from liability to third persons arising from the performance of his professional activities as an attorney on behalf of and with the knowledge of his client.' " *Argoe v. Three Rivers Behavioral Center and Psychiatric Solutions*, 388 S.C. 394,

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400, 697 S.E.2d 551, 554 (2010) (*citing Pye v. Estate of Fox*, 369 S.C. 555, 564, 633 S.E.2d 505, 509 (2006).

35. Where a plaintiff in a negligence action against an attorney is not the attorney's client, no duty of care exists. *See Argoe*, 388 S.C. at 400, 697 S.E.2d at 554 (holding that the appellant "was not owed a duty of care" because she "was not Respondent's client.").

36. Plaintiff has never been Defendants' client with regard to this matter, nor does its Complaint allege an attorney-client relationship existed between Plaintiff and Defendants. As the Complaint makes clear, Plaintiff is merely a third-party medical services provider that provided surgical treatment for Defendants' Client in the past and that provided additional surgical treatment during Defendants' representation of their Client following his December 14, 2018 accident.

37. Defendants' communications with Plaintiff and its staff were in the course and scope of their representation of Client and pursuit of his personal injury claim against the at-fault driver. *See, e.g.,* December 20, 2018 LOP and March 7, 2019 LOP (identifying Defendants' Client, setting forth the date of Client's accident, and addressing protection of claims Plaintiff may have "out of any settlement proceeds we may receive arising out of [Client's accident]"); Pltf.'s Compl. at Ex. 4, Jan. 21, 2019 email from Tina Bennett to Kiara Goodwine ("[Client] has advised our office that he will require surgery. Based upon the serious nature of his injury, and his pre-existing injuries, we would respectfully request that all of his treatment be filed with his private health insurance company.").

38. Plaintiff's Complaint fails to allege any facts to indicate any of Defendants' alleged statements were made outside the course and scope of Defendants' representation of Client.

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39. Therefore, because at all relevant times herein Plaintiff was not Defendants' client, and Defendants' statements to Plaintiff were made in the course and scope of their professional activities on behalf of Client and with his knowledge, Defendants did not owe Plaintiff a duty of care as a matter of law.

40. Accordingly, Plaintiff's cause of action for Negligence is dismissed with prejudice.

II. Plaintiff's Fraud and Constructive Fraud Claims

41. Plaintiff's claims for Fraud and Constructive Fraud are subject to dismissal because Plaintiff failed to allege facts sufficient to establish it had a right to rely on the truth of any representations made to it in connection with this matter.

42. "To establish a cause of action for fraud, the following elements must be proven by clear, cogent, and convincing evidence: (1) a representation of fact; (2) its falsity; (3) its materiality; (4) either knowledge of its falsity or a reckless disregard of its truth or falsity; (5) intent that the representation be acted upon; (6) the hearer's ignorance of its falsity; (7) the hearer's reliance on its truth; (8) the hearer's right to rely thereon; and (9) the hearer's consequent or proximate injury." *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 50, 691 S.E.2d 135, 149 (2010).

43. Further, pursuant to Rule 9(b), SCRCP, "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity." "A complaint is fatally defective if it fails to allege all nine elements of fraud." *Ardis v. Cox*, 314 S.C. 512, 515, 431 S.E.2d 267, 269 (Ct. App. 1993). Where the complaint omits allegations on any element of fraud, the trial court should grant the defendant's motion to dismiss the claim. *Id.*

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a. Availability of Insurance Coverage

44. Plaintiff alleges Defendants knowingly or recklessly made false representations of fact as to: (1) "the amount of insurance coverage available to pay for medical/surgical services [Plaintiff] planned to provide to [Client];" and (2) "[Defendants'] intent to pay [Plaintiff] from any recovery [Defendants] obtained on behalf of [Client]." *See* Pltf.'s Compl. at ¶¶ 47-53.

45. However, while Plaintiff generally alleges it had a right to rely on such representations, *See id.* at ¶ 57, its Complaint fails to state with particularity any facts supporting such a right, as required by Rule 9(b), SCRCP and South Carolina case law.

46. "The right to rely must be determined in light of the plaintiff's duty to use reasonable prudence and diligence under the circumstances in identifying the truth with respect to the representations made to him." *Regions Bank v. Schmauch*, 354 S.C. 648, 672, 582 S.E.2d 432, 445 (Ct. App. 2003). "Moreover, there is no right to rely, as required to establish fraud, where there is no confidential or fiduciary relationship and there is an arm's length transaction between mature, educated people. This is especially true in circumstances where one should have utilized precaution and protection to safeguard his interests." *Id.*

47. Here, no confidential or fiduciary relationship existed between Plaintiff and Defendants, and Plaintiff's Complaint does not allege otherwise. Plaintiff was not Defendants' client; it was merely a third-party provider of medical services to Client.

48. Accordingly, Plaintiff was not entitled, by virtue of the parties' relationship to one another, to rely on Defendants' representations as to insurance coverage or intent to pay. Instead, Plaintiff was under an affirmative duty to use reasonable prudence and diligence to attempt to discover the truth of the representations.

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49. Plaintiff alleges that by January 3, 2019—the date on which Client executed Plaintiff's Financial Policy—all parties involved knew Plaintiff and Highsmith were "out-of-network" healthcare providers under Client's private health insurance. Pltf.'s Compl. at ¶ 14.

50. While Bennett initially emailed Goodwine on January 21, 2019 and indicated "we are not concerned that there will be enough overall coverage to pay the claim," *id.* at Ex. 4, she followed up the same day and notified Goodwine that all of Client's surgical treatment was to be filed with his private health insurance company, and that treatment should not proceed under an assignment or letter of protection. *See id*.

51. Goodwine acknowledged receipt of Bennett's instructions and did not indicate there would be any issues with proceeding in the instructed manner. *See id*.

52. Accordingly, the Court finds that as of January 21, 2019—approximately two (2) months before Client's First Surgery—Plaintiff had actual notice that: (1) the December 20, 2018 LOP would no longer be honored; (2) Defendants did not intend to protect Plaintiff's claims out of any settlement proceeds from Client's personal injury claim; and (3) Plaintiff should file all claims for payment with Client's private health insurance company.

53. Further, Bennett's email to Goodwine did not indicate any claims could or should be filed with Client's underinsured motorist carrier or his occupational accident carrier. *See id.*

54. Assuming, as Plaintiff alleges, that it knew it was an "out-of-network" provider for which claims would not be paid under Client's private health insurance policy, it should have refused Bennett's instructions to file claims with Client's private health insurance company.

55. Further—as of January 21, 2019—because Plaintiff knew Defendants did not intend to protect its claims out of any settlement proceeds, and it allegedly knew there would be no coverage under Client's private health insurance policy, Plaintiff should have known the only

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potential avenue for payment would have been through Client's underinsured motorist and/or occupational accident policies.

56. Plaintiff, in the exercise of reasonable diligence, could and should have taken steps to obtain written confirmations of coverage from the underinsured motorist and occupational accident carriers themselves before furnishing costly surgical and other medical services to Client.

57. In doing so, Plaintiff could have discovered the potential coverage issues and referred Client to an appropriate "in-network" surgeon for further treatment. However, Plaintiff apparently instead chose to rely solely on Bennett's first January 21, 2019 email to Goodwine—expressing only an opinion on available coverage—which, as discussed above, Plaintiff had no right to rely on.

58. Accordingly—because Plaintiff had no right to rely on Bennett's statement regarding the amount of insurance coverage available to pay for Client's medical and surgical expenses, and Plaintiff's Complaint fails to allege any other efforts undertaken by Plaintiff to protect its interests and discover the truth of the matter—Plaintiff's Fraud and Constructive Fraud claims fail as a matter of law and are hereby dismissed with prejudice.

b. The Letters of Protection

59. As an initial matter—to the extent Plaintiff asserts claims for Fraud and Constructive Fraud in connection with Defendants' December 20, 2018 LOP, Plaintiff had no right to rely on any statements contained therein because the letter was effectively revoked in Bennett's second January 21, 2019 email to Goodwine stating that treatment should not proceed under a letter of protection.

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60. Assuming—for purposes of this Order only—that the March 7, 2019 LOP constitutes a contract by which D&M agreed to "protect any portion of [Plaintiff's] bill not paid by private health insurance out of any settlement proceeds we may receive," then by its terms, Plaintiff was required to seek payment from Client's private health insurance before making a claim to any settlement funds.

61. First, Plaintiff never attempted to submit claims for its services to Client's private health insurance carrier.

62. Second, Plaintiff has failed to allege with particularity any facts or circumstances indicating either that: (1) Defendants had no intention of paying Plaintiff under the March 7, 2019 LOP at the time they sent the letter to Plaintiff; or (2) the statements contained in the March 7, 2019 LOP were false at the time they were made. At most, such statements could possibly be construed as contractual promises of D&M.

63. Without more, Defendants' alleged failure to pay Plaintiff under the March 7, 2019 LOP is insufficient to state valid claims for Fraud or Constructive Fraud. *See Davis v. Upton*, 250 S.C. 288, 291, 157 S.E.2d 567, 568 (1967) ("The general rule is that fraud must relate to a present or pre-existing fact, and cannot ordinarily be predicated on unfulfilled promises or statements as to future events."). *See also, id.*, 250 S.C. 288 at 293, 157 S.E.2d at 569 (holding that "[t]he mere breach of a contract does not constitute fraud.").

64. Therefore, as Plaintiff's Fraud and Constructive Fraud claims relate to the March 7, 2019 LOP, they are also dismissed with prejudice.

III. Plaintiff's Unjust Enrichment Claim

65. The essential elements of unjust enrichment are: (1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by

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defendant of the benefit under conditions that make it inequitable for him to retain it without paying its value. *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 15 (Ct. App. 1988).

66. Moreover, speculative claims of future increased value are not a sufficient benefit to support an unjust enrichment claim. *See Bouchard v. Price*, 694 A.2d 670, 673 (R.I. 1997) (holding insufficient "profits that plaintiffs anticipate defendant might obtain by selling the rights to his story at some unspecified time in the future.").

67. Here, Plaintiff alleges it provided surgical services to Client, Pltf.'s Compl. at ¶ 73, and that the provision of such services enhanced the settlement value of Client's claim. *Id.* at ¶74.

68. These allegations are insufficient to support a valid claim for Unjust Enrichment. First, as the Complaint itself admits, Plaintiff provided surgical and other medical services to Client, not to Defendants. Therefore, while Plaintiff clearly conferred a benefit on Client, it did not confer any benefit on Defendants.

69. Second, the potential enhancement in settlement value of Client's claim is too speculative to form the basis of a valid Unjust Enrichment claim. Plaintiff cannot rely on conjecture that as a result of its services, at some indeterminate point in the future, Client's claim may have been resolved for a larger amount, or that Defendants would somehow benefit therefrom.

70. Further, Plaintiff has not alleged any facts to show: (1) whether and how the surgical services rendered to Client affected settlement negotiations, if at all; or (2) whether and how Defendants have realized a benefit based on a purported enhancement in settlement value of Client's claim.

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71. Accordingly, Plaintiff has failed to plead facts sufficient to show it has conferred any benefit on Defendants, or that Defendants have realized any valid, non-speculative benefit as a result of the surgical services performed for Client. Therefore, Plaintiff's Unjust Enrichment claim is dismissed with prejudice.

IV. Breach of Contract Accompanied by a Fraudulent Act

72. In order to state a claim for Breach of Contract Accompanied by a Fraudulent Act, a plaintiff "must plead facts establishing three elements: (1) a breach of contract; (2) fraudulent intent relating to the breaching of the contract and not merely to its making; and (3) a fraudulent act accompanying the breach." *Harper v. Ethridge*, 290 S.C. 112, 119, 348 S.E.2d 374, 378 (Ct. App. 1986). Plaintiff's claim fails for two primary reasons.

73. First—even assuming the March 7, 2019 LOP is a valid contract and that Defendants' alleged failure to pay Plaintiff constitutes a breach thereof—Plaintiff has failed to allege facts establishing fraudulent intent specifically relating to Defendants' alleged breach of the March 7, 2019 LOP.

74. Plaintiff alleges Defendants breached the March 7, 2019 LOP by refusing to pay it any portion of the $30,000.00 in settlement funds recovered for Client. *See* Pltf.'s Compl. at ¶¶ 35, 39, 40-44. Based on the allegations in Plaintiff's Complaint, it appears Defendants' alleged refusal to pay occurred either in late 2020 or early 2021, after Plaintiff sent Client an invoice for its services on or around November 2, 2020.

75. However, all of Plaintiff's allegations of fraud or fraudulent intent on the part of Defendants relate to Bennett's statements to Goodwine in January, 2019 regarding the availability of insurance coverage. Such statements were made approximately two months prior to the March 7, 2019 LOP.

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76. As Plaintiff alleges, "[Defendants] and [Plaintiff] ***entered*** [into] the LOP, with all parties knowing the availability of liability or other insurance coverage was a material term…," *id.* at ¶ 39. Therefore, Plaintiff's allegations relate to the making of the March 7, 2019 LOP, not its alleged breach approximately two years later.

77. Second, Plaintiff has not alleged any fraudulent acts by Defendants accompanying their purported failure to pay Plaintiff under the March 7, 2019 LOP. "[A] fraudulent act is any act characterized by dishonesty in fact, unfair dealing, or the unlawful appropriation of another's property by design." *Harper*, 290 S.C. at 119, 348 S.E.2d at 378.

78. Plaintiff's Complaint contains no allegations of any such dishonest representations of fact, unfair dealing, or unlawful appropriation of property on the part of Defendants.

79. Indeed, as Plaintiff's Complaint admits, "[Defendants] have no explanation on why they have not paid [Plaintiff] the entire $30,000 from the recovery obtained for [Client]." Pltf.'s Compl. at ¶ 39.

80. At most, the matters alleged in Plaintiff's Complaint may constitute a breach of contract. However, for the foregoing reasons, they are insufficient to support a valid claim for Breach of Contract Accompanied by a Fraudulent Act.

81. Therefore, Plaintiff's claim for Breach of Contract Accompanied by a Fraudulent Act is dismissed with prejudice.

WHEREFORE, it is hereby ORDERED, ADJUDGED, and DECREED that:

A. Defendants' Motion to Dismiss Plaintiff's Complaint is GRANTED as to Plaintiff's claims for: (1) Negligence; (2) Fraud; (3) Constructive Fraud; (4) Unjust Enrichment;

and (5) Breach of Contract Accompanied by a Fraudulent Act, and such claims are hereby dismissed with prejudice; and

B. The Court finds Plaintiff has alleged sufficient facts to state a cause of action for: (1) Breach of Contract; and (2) Violation of the South Carolina Unfair Trade Practices Act. Therefore, Defendants' Motion to Dismiss is DENIED as to these claims.

SO ORDERED!

This_____ day of _____, 2022.

_____
The Honorable Edgar W. Dickson
First Judicial Circuit

[Electronic Signature Page Follows]

6837915v.1

ELECTRONICALLY FILED - 2022 Jun 28 2:20 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

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Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Other

So Ordered

s/ Edgar W. Dickson #2153

ELECTRONICALLY FILED - 2023 Apr 05 1:45 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	IN THE NINTH UDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopedics, Inc.,	)	
	)	**AMENDED**
Plaintiff,	)	**ORDER ON DEFENDANTS' MOTION TO DISMISS**
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	
	)	

THIS MATTER comes before the Court on Defendants' Michael A Maucher, Esq. ("Maucher") and Deluca & Maucher, LLP's ("D&M") (collectively, "Defendants") Motion to Dismiss Plaintiff's Complaint, filed October 22, 2021. The Court heard oral argument on Defendants' Motion on March 3, 2022. The Court granted in part and denied in part Defendants' Motion to Dismiss on June 28, 2022. Plaintiff timely moved to reconsider the Order, which was heard on March 3, 2023. As a result of the hearing and with agreement of counsel, the Court enters this Amended Order on Defendants' Motion to Dismiss.

With Court agreement the parties stipulate that the content of the Order or this Amended Order will not be admissible in this lawsuit to prove or disprove any matter of fact or establish or challenge any conclusion of law with respect to Plaintiff's remaining claims for Breach of Contract and violation of the South Carolina Unfair Trade Practices Act. The Order and Amended Order shall have no effect beyond that of which an order on a motion to dismiss would normally have.

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FINDINGS OF FACT

1. Plaintiff Carolina Neurosurgery & Orthopedics, Inc. ("Plaintiff") is a citizen and resident of Charleston County, South Carolina licensed to practice medicine in South Carolina.

2. Jason M. Highsmith, M.D. ("Highsmith") is Plaintiff's primary surgeon.

3. Maucher is a citizen and resident of Charleston County, South Carolina, and he is an attorney licensed to practice law in South Carolina.

4. D&M is a South Carolina Limited Liability Partnership operating as a law practice with offices in Charleston County and Berkeley County, South Carolina.

5. On December 14, 2018, Defendants' client ("Client") was injured in a motor vehicle collision. Shortly thereafter, he retained Defendants to pursue claims against the at-fault driver.

6. As Client was a prior surgery patient of Plaintiff and Highsmith, he selected Plaintiff for surgical treatment of his injuries arising from the accident. Highsmith performed the procedures.

7. On December 20, 2018, at Client's request, D&M sent Plaintiff a letter of protection ("December 20, 2018 LOP"), in which D&M agreed to protect any claim by Plaintiff for the cost of Client's treatment out of any settlement proceeds arising from the accident. The December 20, 2018 LOP is attached to Plaintiff's Complaint as Exhibit 1 and is incorporated herein by reference.

8. On January 3, 2019, Client executed Plaintiff's Financial Policy ("Financial Policy"), which is attached to Plaintiff's Complaint as Exhibit 2 and is incorporated herein by reference.

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9. The Financial Policy provides that Plaintiff will submit claims for payment under a patient's primary health insurance.

10. On January 16, 2019, Kiara Goodwine ("Goodwine"), an employee in Plaintiff's office, contacted D&M to request information regarding the at-fault driver's liability policy limits. On January 21, Tina Bennett, a paralegal with D&M ("Bennett") responded that the at-fault carrier was from North Carolina and would not disclose policy limits without a medical authorization from Client. However, Bennett informed Goodwine that Client carried a total of $1,100,000 in accident coverage under two additional insurance policies.

11. On the same day, Bennett also emailed Goodwine and informed her that based upon the severity of Client's injury and his pre-existing injuries, all of his treatment would need to be filed with his private health insurance and should not proceed under a letter of protection.

12. Goodwine acknowledged receipt of the email and Bennett's instructions. The foregoing emails are attached to Plaintiff's Complaint as Exhibits 4-5 and are incorporated herein by reference.

13. Accordingly, as of January 21, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance.

14. On March 7, 2019, D&M sent a revised letter of protection to Plaintiff ("March 7, 2019 LOP"), stating that D&M would protect whatever amounts Client's private health insurance did not pay out of the proceeds of any settlement of Client's personal injury claim.

15. Bennett's email containing the March 7, 2019 LOP stated that "[t]his LOP covers whatever is NOT paid by private health insurance." Bennett's email and the March 7, 2019 LOP are attached to Plaintiff's Complaint as Exhibit 6 and are incorporated herein by reference.

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16. As of March 7, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance first before seeking payment under the March 7, 2019 LOP.

17. Despite D&M's prior instructions and the express language of the March 7, 2019 LOP, Plaintiff never attempted to confirm its network status with Client's private health insurance carrier prior to rendering surgical services, or to file claims for payment with Client's private health insurance, as is required under Plaintiff's Financial Policy.

18. Highsmith performed Client's first surgery—a C6-7 ACDF surgery—on March 15, 2019 ("First Surgery") at a cost of $62,451.87.

19. As Client's personal injury case developed, it was determined that: (1) the at-fault driver did not have sufficient insurance coverage to fully cover Client's medical treatment; (2) one of Client's other additional policies was inapplicable; and (3) the other additional policy was subject to subrogation and only applicable after Client's primary private health insurance had been exhausted.

20. On April 29, 2019, D&M notified Plaintiff via email of the foregoing issues, stating:

> "Because the at-fault party only had $30,000.00 and [Client's] Underinsured Motorist Coverage does not apply, ALL of the treatment [Client] has received (and will continue to receive) must be filed under his private health insurance. We cannot honor anymore treatment under a Letter of Protection. Please note [Client's] file accordingly."

21. On May 2, 2019, Highsmith performed additional surgery on Client at an approximate cost of $65,000.00 ("Second Surgery").

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22. Despite receiving explicit instructions regarding claim submission and payment on several occasions prior to both surgeries, Plaintiff never attempted to file claims for Client's surgical services with Client's private health insurance.

23. Instead, Plaintiff waited until around November 2, 2020—almost one year after the completion of Client's treatment—to send Client a bill for surgical services in the amount of $125,409.28. Plaintiff's bill is attached to Plaintiff's Complaint as Exhibit 3 and is incorporated herein by reference.

24. Client has made no payments to Plaintiff for the medical and surgical services provided, and Defendants have not disbursed any funds from the $30,000.00 settlement proceeds recovered for Client.

25. Plaintiff filed this action on July 22, 2021, asserting causes of action against Defendants for: (1) Breach of Contract; (2) Breach of Contract Accompanied by a Fraudulent Act; (3) Violation of the South Carolina Unfair Trade Practices Act; (4) Fraud; (5) Constructive Fraud; (6) Unjust Enrichment; and (7) Negligence.

26. Defendants were served with process on September 24, 2021.

27. Defendants filed their Motion to Dismiss Plaintiff's Complaint on October 22, 2021.

PROCEDURAL STANDARD

When ruling on a Motion to Dismiss pursuant to Rule 12(b)(6), SCRCP, "[t]he circuit court may dismiss a claim when the defendant demonstrates the plaintiff's 'failure to state facts sufficient to constitute a cause of action' in the pleadings filed with the court." *Hambrick v. GMAC Mortg. Corp.*, 370 S.C. 118, 121, 634 S.E.2d 5, 7 (Ct. App. 2006) (*citing FOC Lawshe Ltd. P'ship v. Int' l Paper Co.*, 352 S.C. 408, 412, 574 S.E.2d 228, 230 (Ct.App.2002)). If, in

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viewing the complaint in the light most favorable to the plaintiff, the court determines the facts in the complaint are insufficient to entitle the plaintiff to the relief it seeks, the court should grant the motion. *Baird v. Charleston Co.*, 333 S.C. 519, 527, 511 S.E.2d, 69, 73 (1999).

CONCLUSIONS OF LAW

Based upon the foregoing, the Court makes the following Conclusions of Law:

28. The Court has jurisdiction over the subject matter of this case and the parties hereto.

29. Venue is proper in Charleston County, South Carolina.

I. Plaintiff's Negligence Claim

30. Plaintiff's Complaint fails to allege facts sufficient to support a cause of action for Negligence against Defendants because, as a matter of law, Defendants owed no duty of care to Plaintiff.

31. To establish a cause of action for negligence, a plaintiff must show: (1) the defendant owes a duty of care to the plaintiff; (2) the defendant breached that duty by a negligent act or omission; (3) the defendant's breach was the actual and proximate cause of the plaintiff's injury; and (4) the plaintiff suffered an injury or damages. *Roddey v. Wal-Mart Stores East, LP*, 415 S.C. 580, 589, 784 S.E.2d 670, 675 (2016).

32. The existence of a legal duty is an indispensable element of Negligence. See, e.g., S.C. Elec. & Gas Co. v. Utilities Const. Co., 244 S.C. 79, 88, 135 S.E.2d 613, 617 (1964) ("The breach of a legal duty is essential to negligence…Without a violation of such a legal duty, there is no negligence.").

33. For a duty to arise in the context of an attorney's professional activity, an attorney-client relationship must generally exist between the attorney and the party asserting a

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claim for Negligence. *See Holy Loch Distributors, Inc. v. Hitchcock*, 340 S.C. 20, 26, 531 S.E.2d 282, 285 (2000) (stating that in a legal malpractice and negligence action, a plaintiff must establish, among other elements, "the existence of an attorney-client relationship.").

34. "Generally, "an attorney is immune from liability to third persons arising from the performance of his professional activities as an attorney on behalf of and with the knowledge of his client.' " *Argoe v. Three Rivers Behavioral Center and Psychiatric Solutions*, 388 S.C. 394, 400, 697 S.E.2d 551, 554 (2010) (*citing Pye v. Estate of Fox*, 369 S.C. 555, 564, 633 S.E.2d 505, 509 (2006).

35. Where a plaintiff in a negligence action against an attorney is not the attorney's client, no duty of care exists. *See Argoe*, 388 S.C. at 400, 697 S.E.2d at 554 (holding that the appellant "was not owed a duty of care" because she "was not Respondent's client.").

36. Plaintiff has never been Defendants' client with regard to this matter, nor does its Complaint allege an attorney-client relationship existed between Plaintiff and Defendants. As the Complaint makes clear, Plaintiff is merely a third-party medical services provider that provided surgical treatment for Defendants' Client in the past and that provided additional surgical treatment during Defendants' representation of their Client following his December 14, 2018 accident.

37. Defendants' communications with Plaintiff and its staff were in the course and scope of their representation of Client and pursuit of his personal injury claim against the at-fault driver. *See, e.g.,* December 20, 2018 LOP and March 7, 2019 LOP (identifying Defendants' Client, setting forth the date of Client's accident, and addressing protection of claims Plaintiff may have "out of any settlement proceeds we may receive arising out of [Client's accident]"); Pltf.'s Compl. at Ex. 4, Jan. 21, 2019 email from Tina Bennett to Kiara Goodwine ("[Client] has

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advised our office that he will require surgery. Based upon the serious nature of his injury, and his pre-existing injuries, we would respectfully request that all of his treatment be filed with his private health insurance company.").

38. Plaintiff's Complaint fails to allege any facts to indicate any of Defendants' alleged statements were made outside the course and scope of Defendants' representation of Client.

39. Therefore, because at all relevant times herein Plaintiff was not Defendants' client, and Defendants' statements to Plaintiff were made in the course and scope of their professional activities on behalf of Client and with his knowledge, Defendants did not owe Plaintiff a duty of care as a matter of law.

40. Accordingly, Plaintiff's cause of action for Negligence is dismissed with prejudice.

II. Plaintiff's Fraud and Constructive Fraud Claims

41. Plaintiff's claims for Fraud and Constructive Fraud are subject to dismissal because Plaintiff failed to allege facts sufficient to establish it had a right to rely on the truth of any representations made to it in connection with this matter.

42. "To establish a cause of action for fraud, the following elements must be proven by clear, cogent, and convincing evidence: (1) a representation of fact; (2) its falsity; (3) its materiality; (4) either knowledge of its falsity or a reckless disregard of its truth or falsity; (5) intent that the representation be acted upon; (6) the hearer's ignorance of its falsity; (7) the hearer's reliance on its truth; (8) the hearer's right to rely thereon; and (9) the hearer's consequent or proximate injury." *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 50, 691 S.E.2d 135, 149 (2010).

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43. Further, pursuant to Rule 9(b), SCRCP, "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity." "A complaint is fatally defective if it fails to allege all nine elements of fraud." *Ardis v. Cox*, 314 S.C. 512, 515, 431 S.E.2d 267, 269 (Ct. App. 1993). Where the complaint omits allegations on any element of fraud, the trial court should grant the defendant's motion to dismiss the claim. *Id.*

a. Availability of Insurance Coverage

44. Plaintiff alleges Defendants knowingly or recklessly made false representations of fact as to: (1) "the amount of insurance coverage available to pay for medical/surgical services [Plaintiff] planned to provide to [Client];" and (2) "[Defendants'] intent to pay [Plaintiff] from any recovery [Defendants] obtained on behalf of [Client]." *See* Pltf.'s Compl. at ¶¶ 47-53.

45. However, while Plaintiff generally alleges it had a right to rely on such representations, *See id.* at ¶ 57, its Complaint fails to state with particularity any facts supporting such a right, as required by Rule 9(b), SCRCP and South Carolina case law.

46. "The right to rely must be determined in light of the plaintiff's duty to use reasonable prudence and diligence under the circumstances in identifying the truth with respect to the representations made to him." *Regions Bank v. Schmauch*, 354 S.C. 648, 672, 582 S.E.2d 432, 445 (Ct. App. 2003). "Moreover, there is no right to rely, as required to establish fraud, where there is no confidential or fiduciary relationship and there is an arm's length transaction between mature, educated people. This is especially true in circumstances where one should have utilized precaution and protection to safeguard his interests." *Id*.

47. Here, no confidential or fiduciary relationship existed between Plaintiff and Defendants, and Plaintiff's Complaint does not allege otherwise. Plaintiff was not Defendants' client; it was merely a third-party provider of medical services to Client.

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48. Accordingly, Plaintiff was not entitled, by virtue of the parties' relationship to one another, to rely on Defendants' representations as to insurance coverage or intent to pay. Instead, Plaintiff was under an affirmative duty to use reasonable prudence and diligence to attempt to discover the truth of the representations.

49. Plaintiff alleges that by January 3, 2019—the date on which Client executed Plaintiff's Financial Policy—all parties involved knew Plaintiff and Highsmith were "out-of-network" healthcare providers under Client's private health insurance. Pltf.'s Compl. at ¶ 14.

50. While Bennett initially emailed Goodwine on January 21, 2019 and indicated "we are not concerned that there will be enough overall coverage to pay the claim," *id.* at Ex. 4, she followed up the same day and notified Goodwine that all of Client's surgical treatment was to be filed with his private health insurance company, and that treatment should not proceed under an assignment or letter of protection. *See id*.

51. Goodwine acknowledged receipt of Bennett's instructions and did not indicate there would be any issues with proceeding in the instructed manner. *See id*.

52. Accordingly, the Court finds that as of January 21, 2019—approximately two (2) months before Client's First Surgery—Plaintiff had actual notice that: (1) the December 20, 2018 LOP would no longer be honored; (2) Defendants did not intend to protect Plaintiff's claims out of any settlement proceeds from Client's personal injury claim; and (3) Plaintiff should file all claims for payment with Client's private health insurance company.

53. Further, Bennett's email to Goodwine did not indicate any claims could or should be filed with Client's underinsured motorist carrier or his occupational accident carrier. *See id.*

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54. Assuming, as Plaintiff alleges, that it knew it was an "out-of-network" provider for which claims would not be paid under Client's private health insurance policy, it should have refused Bennett's instructions to file claims with Client's private health insurance company.

55. Further—as of January 21, 2019—because Plaintiff knew Defendants did not intend to protect its claims out of any settlement proceeds, and it allegedly knew there would be no coverage under Client's private health insurance policy, Plaintiff should have known the only potential avenue for payment would have been through Client's underinsured motorist and/or occupational accident policies.

56. Plaintiff, in the exercise of reasonable diligence, could and should have taken steps to obtain written confirmations of coverage from the underinsured motorist and occupational accident carriers themselves before furnishing costly surgical and other medical services to Client.

57. In doing so, Plaintiff could have discovered the potential coverage issues and referred Client to an appropriate "in-network" surgeon for further treatment. However, Plaintiff apparently instead chose to rely solely on Bennett's first January 21, 2019 email to Goodwine—expressing only an opinion on available coverage—which, as discussed above, Plaintiff had no right to rely on.

58. Accordingly—because Plaintiff had no right to rely on Bennett's statement regarding the amount of insurance coverage available to pay for Client's medical and surgical expenses, and Plaintiff's Complaint fails to allege any other efforts undertaken by Plaintiff to protect its interests and discover the truth of the matter—Plaintiff's Fraud and Constructive Fraud claims fail as a matter of law and are hereby dismissed with prejudice.

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b. The Letters of Protection

59. As an initial matter—to the extent Plaintiff asserts claims for Fraud and Constructive Fraud in connection with Defendants' December 20, 2018 LOP, Plaintiff had no right to rely on any statements contained therein because the letter was effectively revoked in Bennett's second January 21, 2019 email to Goodwine stating that treatment should not proceed under a letter of protection.

60. Assuming—for purposes of this Order only—that the March 7, 2019 LOP constitutes a contract by which D&M agreed to "protect any portion of [Plaintiff's] bill not paid by private health insurance out of any settlement proceeds we may receive," then by its terms, Plaintiff was required to seek payment from Client's private health insurance before making a claim to any settlement funds.

61. First, Plaintiff never attempted to submit claims for its services to Client's private health insurance carrier.

62. Second, Plaintiff has failed to allege with particularity any facts or circumstances indicating either that: (1) Defendants had no intention of paying Plaintiff under the March 7, 2019 LOP at the time they sent the letter to Plaintiff; or (2) the statements contained in the March 7, 2019 LOP were false at the time they were made. At most, such statements could possibly be construed as contractual promises of D&M.

63. Without more, Defendants' alleged failure to pay Plaintiff under the March 7, 2019 LOP is insufficient to state valid claims for Fraud or Constructive Fraud. *See Davis v. Upton*, 250 S.C. 288, 291, 157 S.E.2d 567, 568 (1967) ("The general rule is that fraud must relate to a present or pre-existing fact, and cannot ordinarily be predicated on unfulfilled

promises or statements as to future events."). *See also, id.*, 250 S.C. 288 at 293, 157 S.E.2d at 569 (holding that "[t]he mere breach of a contract does not constitute fraud.").

64. Therefore, as Plaintiff's Fraud and Constructive Fraud claims relate to the March 7, 2019 LOP, they are also dismissed with prejudice.

III. Plaintiff's Unjust Enrichment Claim

65. The essential elements of unjust enrichment are: (1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by defendant of the benefit under conditions that make it inequitable for him to retain it without paying its value. *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 15 (Ct. App. 1988).

66. Moreover, speculative claims of future increased value are not a sufficient benefit to support an unjust enrichment claim. *See Bouchard v. Price*, 694 A.2d 670, 673 (R.I. 1997) (holding insufficient "profits that plaintiffs anticipate defendant might obtain by selling the rights to his story at some unspecified time in the future.").

67. Here, Plaintiff alleges it provided surgical services to Client, Pltf.'s Compl. at ¶ 73, and that the provision of such services enhanced the settlement value of Client's claim. *Id.* at ¶74.

68. These allegations are insufficient to support a valid claim for Unjust Enrichment. First, as the Complaint itself admits, Plaintiff provided surgical and other medical services to Client, not to Defendants. Therefore, while Plaintiff clearly conferred a benefit on Client, it did not confer any benefit on Defendants.

69. Second, the potential enhancement in settlement value of Client's claim is too speculative to form the basis of a valid Unjust Enrichment claim. Plaintiff cannot rely on

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conjecture that as a result of its services, at some indeterminate point in the future, Client's claim may have been resolved for a larger amount, or that Defendants would somehow benefit therefrom.

70. Further, Plaintiff has not alleged any facts to show: (1) whether and how the surgical services rendered to Client affected settlement negotiations, if at all; or (2) whether and how Defendants have realized a benefit based on a purported enhancement in settlement value of Client's claim.

71. Accordingly, Plaintiff has failed to plead facts sufficient to show it has conferred any benefit on Defendants, or that Defendants have realized any valid, non-speculative benefit as a result of the surgical services performed for Client. Therefore, Plaintiff's Unjust Enrichment claim is dismissed with prejudice.

IV. Breach of Contract Accompanied by a Fraudulent Act

72. In order to state a claim for Breach of Contract Accompanied by a Fraudulent Act, a plaintiff "must plead facts establishing three elements: (1) a breach of contract; (2) fraudulent intent relating to the breaching of the contract and not merely to its making; and (3) a fraudulent act accompanying the breach." *Harper v. Ethridge*, 290 S.C. 112, 119, 348 S.E.2d 374, 378 (Ct. App. 1986). Plaintiff's claim fails for two primary reasons.

73. First—even assuming the March 7, 2019 LOP is a valid contract and that Defendants' alleged failure to pay Plaintiff constitutes a breach thereof—Plaintiff has failed to allege facts establishing fraudulent intent specifically relating to Defendants' alleged breach of the March 7, 2019 LOP.

74. Plaintiff alleges Defendants breached the March 7, 2019 LOP by refusing to pay it any portion of the $30,000.00 in settlement funds recovered for Client. *See* Pltf.'s Compl. at ¶¶

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35, 39, 40-44. Based on the allegations in Plaintiff's Complaint, it appears Defendants' alleged refusal to pay occurred either in late 2020 or early 2021, after Plaintiff sent Client an invoice for its services on or around November 2, 2020.

75. However, all of Plaintiff's allegations of fraud or fraudulent intent on the part of Defendants relate to Bennett's statements to Goodwine in January, 2019 regarding the availability of insurance coverage. Such statements were made approximately two months prior to the March 7, 2019 LOP.

76. As Plaintiff alleges, "[Defendants] and [Plaintiff] ***entered*** [into] the LOP, with all parties knowing the availability of liability or other insurance coverage was a material term…," *id.* at ¶ 39. Therefore, Plaintiff's allegations relate to the making of the March 7, 2019 LOP, not its alleged breach approximately two years later.

77. Second, Plaintiff has not alleged any fraudulent acts by Defendants accompanying their purported failure to pay Plaintiff under the March 7, 2019 LOP. "[A] fraudulent act is any act characterized by dishonesty in fact, unfair dealing, or the unlawful appropriation of another's property by design." *Harper*, 290 S.C. at 119, 348 S.E.2d at 378.

78. Plaintiff's Complaint contains no allegations of any such dishonest representations of fact, unfair dealing, or unlawful appropriation of property on the part of Defendants.

79. Indeed, as Plaintiff's Complaint admits, "[Defendants] have no explanation on why they have not paid [Plaintiff] the entire $30,000 from the recovery obtained for [Client]." Pltf.'s Compl. at ¶ 39.

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80. At most, the matters alleged in Plaintiff's Complaint may constitute a breach of contract. However, for the foregoing reasons, they are insufficient to support a valid claim for Breach of Contract Accompanied by a Fraudulent Act.

81. Therefore, Plaintiff's claim for Breach of Contract Accompanied by a Fraudulent Act is dismissed with prejudice.

WHEREFORE, it is hereby ORDERED, ADJUDGED, and DECREED that:

A. Defendants' Motion to Dismiss Plaintiff's Complaint is GRANTED as to Plaintiff's claims for: (1) Negligence; (2) Fraud; (3) Constructive Fraud; (4) Unjust Enrichment; and (5) Breach of Contract Accompanied by a Fraudulent Act, and such claims are hereby dismissed with prejudice; and

B. The Court finds Plaintiff has alleged sufficient facts to state a cause of action for: (1) Breach of Contract; and (2) Violation of the South Carolina Unfair Trade Practices Act. Therefore, Defendants' Motion to Dismiss is DENIED as to these claims.

SO ORDERED!

This_____ day of March, 2023.

_____
The Honorable Edgar W. Dickson
First Judicial Circuit

[Electronic Signature Page Follows]

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Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Other

IT IS SO ORDERED.

Edgar W. Dickson

ELECTRONICALLY FILED - 2024 Aug 26 2:29 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP Defendants.	**ORDER GRANTING PLAINTIFF'S MOTION TO AMEND COMPLAINT AND POSTPONING HEARING ON DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

THIS MATTER CAME BEFORE THE COURT on August 19, 2024, for a hearing on the Plaintiff's Motion to Amend its Complaint and the Defendants' Motion for Summary Judgment. Thomas A. Pendarvis, Esq. appeared as counsel for Plaintiff, and Skyler C. Wilson, Esq. appeared as counsel for Defendants.

After reviewing the Plaintiff's motion, supporting and opposing memoranda, and hearing arguments of counsel, the Motion to Amend is GRANTED, and the hearing on the Defendants' Motion for Summary Judgment is POSTPONED until 60 days after this Order is signed to give the parties time for additional discovery, including depositions of individuals or entities already deposed in this case.

AND IT IS SO ORDERED!

Roger M. Young, Sr.
Presiding Circuit Court judge

August 21, 2024

Charleston, South Carolina

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Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Amend

It is so ordered.

/s Roger M. Young, Sr. S.C. Circuit Judge 2134

ELECTRONICALLY FILED - 2024 Nov 06 2:05 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP Defendants.	**ORDER DENYING DEFENDANTS' MOTION TO STRIKE PLAINTIFF'S SECOND AMENDED COMPLAINT AND POSTPONING HEARING ON DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

THIS MATTER CAME BEFORE THE COURT on November 4 2024, for a hearing on the Defendants' Motion to Strike Plaintiff's Second Amended Complaint and the Defendants' Motion for Summary Judgment. Thomas A. Pendarvis, Esq. appeared as counsel for Plaintiff, and Skyler C. Wilson, Esq. appeared as counsel for Defendants.

After reviewing the Defendants' motion to strike, supporting memoranda, and hearing arguments of counsel, the Defendants' Motion to Strike Plaintiff's Second Amended Complaint is DENIED, and the hearing on the Defendants' Motion for Summary Judgment is continued until another term of court.

AND IT IS SO ORDERED!

Dale E. Van Slambrook
Presiding Circuit Court judge

November 5, 2024

Charleston, South Carolina

ELECTRONICALLY FILED - 2024 Nov 06 2:05 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Charleston Common Pleas

Case Caption: Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al

Case Number: 2021CP1003379

Type: Order/Other

And It Is So Ordered!

s/Dale E. Van Slambrook S.C. Circuit Court Judge #2781

ELECTRONICALLY FILED - 2025 Jan 31 10:07 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2021-CP-10-03379

CAROLINA NEUROSURGERY & ORTHOPAEDICS, INC.
PLAINTIFF(S)

MICHAEL A. MAUCHER, ESQ.
DELUCA & MAUCHER, LLP
DEFENDANT(S)

Submitted by: The Court.	**Attorney for :** ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT**. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☒ **DECISION BY THE COURT**. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court:

This matter came before the Court on Defendant's Motion to Reconsider, filed on November 18, 2024, which asks this Court to reconsider its ruling in its November 6, 2024 Order denying Defendant's Motion to Strike. The Court timely received a copy of the Motion for Reconsideration; a Memorandum in opposition was filed by Plaintiff.

"The purpose of Rule 59(e), SCRCP, to alter or amend the judgment is to request the trial judge to reconsider the matters properly encompassed in a decision on the merits." *Arnold v. State*, 309 S.C. 157, 172, 420 S.E.2d 834, 842 (1992). "A party may wish to file such motion when she believes the court has misunderstood, failed to fully consider, or perhaps failed to rule on an argument or issue, and the party wishes for the court to reconsider or rule on it. A party *must* file such a motion when an issue or argument has been raised but not rule on, in order to preserve it for appellate review." *Elam v. South Carolina Dept. of Transp.*, 361 S.C. 9, 24, 602 S.E.2d 772, 780 (2004) (emphasis in original). "A party cannot use a motion to reconsider to present an issue he could have raised prior to judgment but did not." *Anderson Memorial Hosp., Inc., v. Hagen*, 313 S.C. 389, 434 S.E.2d 268 (1993); *See also Arnold*, 309 S.C. at 172-173, 420 S.E.2d at 842.

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After consideration of the record, as well as the various interests balanced by the Court at the time of the ruling, the Defendant's Motion to Reconsider is heard and is respectfully Denied. This motion is disposed of without the necessity of a hearing and decided on the record and briefs.

ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

Additional Information for the Clerk : _____

_____

INFORMATION FOR THE JUDGMENT INDEX **Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.**		
Judgment in Favor of (List name(s) below)	**Judgment Against (List name(s) below)**	**Judgment Amount To be Enrolled (List amount(s) below)**
		$
		$
		$
If applicable, describe the property, including tax map information and address, referenced in the order:		

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk.
Note: Title abstractors and researchers should refer to the official court order for judgment details.
E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

	2781	
Circuit Court Judge	**Judge Code**	**Date**

For Clerk of Court Office Use Only

This judgment was entered on the day of , 20 and a copy mailed first class or placed in the appropriate attorney's box on this day of , 20 to attorneys of record or to parties (when appearing pro se) as follows:

ATTORNEY(S) FOR THE PLAINTIFF(S)	**ATTORNEY(S) FOR THE DEFENDANT(S)**
	CLERK OF COURT

Court Reporter:

E-Filing Note: In E-Filing counties, the date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgement to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

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ELECTRONICALLY FILED - 2025 Jan 31 10:07 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Charleston Common Pleas

Case Caption: Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al

Case Number: 2021CP1003379

Type: Order/Other

And It Is So Ordered!

s/Dale E. Van Slambrook S.C. Circuit Court Judge #2781

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF Charleston
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2021CP1003379

Carolina Neurosurgery & Orthopedics Inc
PLAINTIFF(S)

Michael A Maucher et al
DEFENDANT(S)

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT**. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☑ **DECISION BY THE COURT**. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** *(CHECK APPLICABLE BOX)*: ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☑ Statement of Judgment by the Court:

Statement of Judgment on the following page.

ORDER INFORMATION

This order ☐ ends ☑ does not end the case. ☑ See Page 2 for additional information.

For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 04/03/2025 .

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

ELECTRONICALLY FILED - 2025 Apr 03 4:33 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

ELECTRONICALLY FILED - 2025 Apr 03 4:33 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Court Reporter:

E-Filing Note: The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

This matter was before the Court on March 31, 2025. Thomas Pendarvis appeared on behalf of Plaintiff and Skyler Wilson appeared on behalf of Defendants. Defendants Michael A. Maucher, Esq. and Deluca & Maucher, LLP's Motion for Summary Judgment is granted.

The Court finds that Plaintiff's breach of contract, revised SCUPTA, negligent misrepresentation, and promissory estoppel claims are all preempted by the findings in the Order granting Defendant's Motion to Dismiss.

In addition, the Court finds that Plaintiff cannot prove the necessary elements for each claim. Specifically the Court finds the following:

1.Plaintiff's cannot prove the necessary elements of a breach of contract claim because there was no legally enforceable contract between Plaintiff and Defendant;

2.Defendants did not violate the South Carolina Unfair Trade Practices Act as Defendants were not engaged in a "trade or commerce" with Plaintiff;

3.Plaintiff's cannot prove the necessary elements of negligent misrepresentation because Plaintiff cannot establish Defendants made a false statement to Plaintiff or that Plaintiff actually relied on those statements; and

4.Plaintiff cannot prove the necessary elements for promissory estoppel because there is no evidence that Defendant made unambiguous promise to pay for Client's medical bills.

Therefore, Defendants' Motion for Summary Judgment is granted. Defendants' counsel shall prepare a more formal order within twenty (20) days.

IT IS SO ORDERED.

ELECTRONICALLY FILED - 2025 Apr 03 4:33 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Electronic Form 4

So Ordered

Jessica A. Salvini

ELECTRONICALLY FILED - 2025 May 02 8:37 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	IN THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopaedics, Inc.,	)	
	)	**ORDER GRANTING SUMMARY JUDGMENT**
Plaintiff,	)	
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	
	)	

Plaintiff is a medical practice that treated a client of Defendants after the client sustained injuries in a car accident. When the amount of insurance proceeds recovered did not cover the client's medical bills with Plaintiff, Plaintiff sued the client and, separately in the present action, the client's attorney and law firm, seeking under multiple theories to recover those medical costs.

This matter came before the Court on March 31, 2025, for a hearing on Defendants' Motion for Summary Judgment. Attorney Thomas Pendarvis appeared on behalf of Plaintiff Carolina Neurosurgery & Orthopaedics, Inc., and Attorney Skyler Wilson appeared on behalf of Defendants Michael A. Maucher, Esq. and DeLuca & Maucher, LLP. After considering the memoranda of counsel filed prior to the hearing and arguments at the hearing, this Court GRANTS Summary Judgment to Defendants. Plaintiff's claims are preempted by a prior order of this Court and there are no genuine issues of material fact on one or more elements of each of Plaintiff's claims.

FINDINGS OF FACT

Defendants' Client was injured in a car accident on December 14, 2018. Shortly thereafter, he retained Defendants to pursue claims against the at-fault driver. Before the

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accident, Client was a patient of Dr. Jason Highsmith and chose to return to Dr. Highsmith to treat the injuries he sustained in the car accident.

Upon Plaintiff's requests, Defendants sent Plaintiff a letter of protection on December 20, 2018, that stated:

> Please accept this correspondence as our Law Firm's agreement to protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance.

In order to receive treatment, Client executed Plaintiff's Financial Policy, under which the policy stated: "If you have insurance" that Plaintiff "will file with [the patient's] primary insurance." The Financial Policy also stated the patient may be responsible for all of part of the balance not paid by the insurance company. At the time, Client had primary health insurance through Blue Cross/Blue Shield. Defendants were not a party to the Financial Policy. Client then began receiving treatment with Plaintiff and Dr. Highsmith.

Afterwards, staff with Plaintiff and Defendants communicated about insurance. On January 21, 2019, Defendant's paralegal responded to an inquiry from Plaintiff's employee regarding the "limits" for Client. Defendants' paralegal explained the at-fault driver's carrier would not disclose its insurance limits, and stated: "Because [Client] carries $100,000.00 in Underinsured Motorist Coverage on his at-home policy with Safeco, and there is $1,000,000.00 in 'Occupational Accident Coverage' to pay bills and wages under the One Beacon Policy, we are not concerned that there will be enough over all coverage to pay the claim." But hours later the same day after learning Client needed surgery, Defendants' paralegal emailed Plaintiff's employee, requesting Plaintiff file with Client's private health insurance and that it was best "if we NOT do the treatment under an Assignment/Letter of Protection." Plaintiff's employee said "Okay thanks for the update."

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Defendants then sent Plaintiff a revised Letter of Protection on March 7, 2019, stating:

> Please accept this correspondence as our Law Firm's agreement to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance.

That same day, Client completed a Health Insurance Verification form for his upcoming surgery, providing Plaintiff with his BlueCross/BlueShield insurance information. Dr. Highsmith performed Client's first surgery on March 15, 2019 (First Surgery) and charged Client $58,697.41. On May 2, 2019, Dr. Highsmith performed additional surgery on Client, charging him an additional $62,451.87 (Second Surgery). In total, Plaintiff charged Client $125,409.28.

However, Plaintiff never filed claims with Client's private health insurance. Defendants' paralegal contacted Plaintiff's employee on January 3, 2020, reminding her of the Letters of Protection and that it appeared Client's health insurance did not pay any of Plaintiff's bills. Defendants' paralegal explained there was only $30,000 in coverage to pay the claim and they needed to discuss how to allocate that amount amongst everyone. Because Client was unable to pay for Plaintiff's services, Plaintiff sued client under its Financial Policy in May 2021, but resolved that case prior to trial.

Current Lawsuit & Procedural History

Plaintiff filed this action in July 2021, seeking to recover its medical costs directly from Defendants based on seven different claims. Defendants moved to dismiss Plaintiff's claims, which Judge Dickson granted in part, and the only remaining claims were for (1) breach of contract and (2) SCUTPA violation. That order made numerous findings of fact and conclusions of law that have not been appealed.

After substantial discovery, Defendants moved for summary judgment in August 2023. Plaintiff, however, was granted leave to amend the complaint to alter its theories of recovery and

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add claims for negligent misrepresentation and promissory estoppel. Plaintiff amended the complaint a second time, further changing its theories of recovery but leaving the four causes of action. The parties engaged in additional discovery and depositions, and Defendants' motion for summary judgment was rescheduled for a hearing before this Court. Defendants and Plaintiff each submitted memoranda supporting their positions, and the Court heard argument on March 31, 2025. This Court GRANTED Defendants summary judgment on April 3, 2025, and now issues its formal opinion.

STANDARD OF REVIEW

"Summary judgment is appropriate 'if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.'" *Russell v. Wachovia Bank, N.A.*, 353 S.C. 208, 217, 578 S.E.2d 329, 334 (2003) (quoting Rule 56(c), SCRCP). Summary judgment's purpose is to expedite the disposition of cases not requiring a fact finder. *Nakatsu v. Encompass Indem. Co.*, 390 S.C. 172, 177, 700 S.E.2d 283, 286 (Ct. App. 2010).

The burden of proof rests with the party seeking summary judgment; however, the non-moving party must make a showing sufficient to establish the existence of an essential element on which it will bear the burden to prove at trial. *Baughman v. Am. Tel. & Tel. Co*., 306 S.C. 101, 115, 410 S.E.2d 537, 545 (1991). In determining whether summary judgment is appropriate, the evidence is viewed in the light most favorable to the non-moving party. *Edgewater on Broad Creek Owners Ass'n, Inc. v. Ephesian Ventures, LLC,* 430 S.C. 400, 407, 845 S.E.2d 211, 214 (Ct. App. 2020).

The "mere scintilla" standard does not apply to defeat summary judgment, but instead the party must establish a genuine issue of material fact. *Kitchen Planners, LLC v. Friedman*, 440 S.C. 456, 463, 892 S.E.2d 297, 301 (2023). "A fact is material if it 'might affect the outcome of

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the suit under the governing law.'" *Libertarian Party of Va. v. Judd*, 718 F.3d 308, 313 (4th Cir. 2013) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)). A dispute is "genuine" if "a reasonable jury could return a verdict for the non-moving party." *Strothers v. City of Laurel*, 895 F.3d 317, 326 (4th Cir. 2018) (quoting *Anderson*, 477 U.S. at 248). It is not sufficient for a party to create an inference that is not reasonable or an issue of fact that is not genuine. *Town of Hollywood v. Floyd*, 403 S.C. 466, 477, 744 S.E.2d 161, 166 (2013).

CONCLUSIONS OF LAW

I. Plaintiff's claims are preempted by the unappealed findings of fact and conclusions of law in Judge Dickson's Order that are the law of the case.

Defendants argued that Judge Dickson's Order dismissing the majority of Plaintiff's claims preempted Plaintiff's remaining claims because the Order made multiple findings of fact and conclusions of law on central issues to the case that were not appealed. Plaintiff did not address Defendants' argument on the effect of the order in its brief or in arguments at the hearing. This Court agrees the Order preempts Plaintiff's claims.

"This State has a long-standing rule that one judge of the same court cannot overrule another." *Shirley's Iron Works, Inc. v. City of Union*, 403 S.C. 560, 573, 743 S.E.2d 778, 785 (2013). If a ruling is not appealed, whether it is wrong or right, it becomes the law of the case. *Id.* "The doctrine of the law of the case applies to an order or ruling which finally determines a substantial right." *Id.* (quoting *Weil v. Weil*, 299 S.C. 84, 89, 382 S.E.2d 471, 473 (Ct. App. 1989)). If the order, however, merely decides a point collateral to the issues of the case, it is not binding and can be reconsidered before a final order on the merits. *Id.*

Judge Dickson's Order is the law of the case. It decided a substantial right—dismissing Plaintiff's claims for (1) breach of contract accompanied by a fraudulent act; (2) fraud; (3) constructive fraud; (4) unjust enrichment and (5) negligence. The claims that were dismissed were based, in part, on allegations related to statements about insurance coverage. The Order

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made numerous findings of fact and conclusions of law that Plaintiff has not appealed. Because the Order ruled on important issues, not collateral issues, and was decided by Judge Dickson, this Court cannot overrule or modify the Order. Wrong or right, the Order is the law of the case.

As an initial matter, this Court recognizes the Order states it will not be "admissible" to prove facts or law for the "remaining claims of Breach of Contract and" SCUTPA. Defendants argued this language does not prevent the Court from finding the Order binding on Plaintiff's current claims because after the Order, Plaintiff twice amended its complaint and added claims. Specifically, Defendants argued that Plaintiff's breach of contract and SCUTPA claims were previously based on the letters of protection, but then were amended to be based on the email from Defendants' paralegal about insurance. Plaintiff did not respond to Defendants' argument in its brief or at the hearing. This Court agrees with Defendants and finds the Order applies to Plaintiff's altered claims of breach of contract and violation of SCUTPA, and also applies to the new claims for negligent misrepresentation and promissory estoppel.

This Court finds the following findings in the Order are the law of the case and preempt Plaintiff's claims:

- "as of January 21, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance." Order, ¶ 13.
- "as of March 7, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance first before seeking payment under the March 7, 2019 LOP." Order, ¶ 16.
- "Plaintiff never attempted to confirm its in-network status with Client's private health insurance carrier prior to rendering surgical services, or to file claims for payment with Client's private health insurance, as is required under Plaintiff's Financial Policy." Order, ¶ 17.
- "On April 29, 2019, D&M notified Plaintiff via email of the foregoing issues" (Order, ¶ 20), referring to Paragraph 19 that states it was determined the at-fault driver did not have sufficient insurance coverage, one policy was inapplicable, and the "additional policy was subject to subrogation only applicable after Client's primary private health insurance had been exhausted."
- "Despite receiving explicit instructions regarding claim submission and payment on several occasions prior to both surgeries, Plaintiff never attempted

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to file claims for Client's surgical services with Client's private health insurance. Order, ¶ 22.

- Under "Fraud" and "Availability of Insurance Coverage" finding Plaintiff was not entitled, by virtue of the parties' relationship to one another, to rely on Defendants' representations as to insurance coverage or intent to pay. Instead, Plaintiff was under an affirmative duty to use reasonable prudence and diligence to attempt to discover the truth of the representations." Order, ¶ 48.
- "While Bennett initially emailed Goodwine on January 21, 2019 and indicated 'we are not concerned that there will be enough overall coverage to pay the claim,' . . . she followed up that same day and notified Goodwine that all of Client's surgical treatment was to be filed with his private health insurance company, and that treatment should not proceed under an assignment or letter of protection." Order, ¶ 50.
- "as of January 21, 2019—approximately two (2) months before Client's First Surgery—Plaintiff had actual notice that . . . (2) Defendants did not intend to protect Plaintiff's claims out of any settlement proceeds from Client's personal injury claim; and (3) Plaintiff should file all claims for payment with Client's private health insurance company." Order, ¶ 52.
- "Bennett's email to Goodwine did not indicate any claims could or should be filed with Client's underinsured motorist carrier or his occupational accident carrier." Order, ¶ 53.
- Plaintiff "should have refused Bennett's instructions to file claims with Client's private health insurance company." Order, ¶ 54.
- "Plaintiff should have known the only potential avenue for payment would have been through Client's underinsured motorist and/or occupational accident policies." Order, ¶ 55.
- "Plaintiff, in the exercise of reasonable diligence, could and should have taken steps to obtain written confirmations of coverage from the underinsured motorist and occupational accident carriers themselves before furnishing costly surgical and other medical services to Client. Order, ¶ 56.
- "Plaintiff apparently instead chose to rely solely on Bennett's first January 21, 2019 email to Goodwine—expressing only an opinion on available coverage—which, as discussed above, Plaintiff had no right to rely on." Order, ¶ 57.

Plaintiff alleges four causes of action: (1) breach of contract; (2) SCUTPA violation; (3) negligent misrepresentation; and (4) promissory estoppel, all of which are preempted by the Order.

1. Plaintiff's breach of contract claim is preempted by the findings in the Order.

Plaintiff's breach of contract action is based on allegations that the parties "entered into a contract wherein Carolina Neurosurgery would provide medical services to the Lawyers' client

based on the Lawyers' representations about insurance coverage." The Order finds that Plaintiff was on notice as of January 2019 of the need to seek payment from private health insurance, and that Defendants did not intend to protect any claims to insurance proceeds—*after* the statement about insurance proceeds and before any further letter of protection. The Order also finds Plaintiff was aware as of April 29, 2019, that the additional policy had a subrogation requirement and required filing with private health insurance first. Moreover, the Order clearly states Plaintiff had no right to rely on statements about coverage, the statement about insurance coverage was only an opinion, and Plaintiff needed to perform its own due diligence about the referenced policies and seek confirmations of coverage from the carriers before surgery.

To succeed on its breach of contract claim, Plaintiff would have to prove it agreed to provide medical services because Defendants made statements about insurance coverage. However, this conflicts with the Order's findings above that are the law of the case. Therefore, this Court grants Defendants summary judgment on Plaintiff's breach of contract claim.

2. Plaintiff's SCUTPA claim is preempted by the findings in the Order.

In its SCUTPA claim, Plaintiff asserts that Defendants "engaged in unfair or deceptive acts or practices of trade or commerce." In discovery, Plaintiff explained that the unfair or deceptive act was (1) making "representations, assurances, and promises to a healthcare provider that payments for elective surgical procedures . . . would be paid out of $1,100,000 of liability coverage." Plaintiff also asserted that it was unfair or deceptive "for a lawyer and a law firm to make false representations about email communications that never occurred"—referencing the April 29, 2019 email from Defendants' paralegal to Plaintiff's employee and alleging Plaintiff did not receive the email and did not know about it until after the surgeries were performed.

The Order explicitly finds that Plaintiff was notified of the April 29, 2019 email. Order, ¶¶ 19-20. Wrong or right, that finding is the law of the case and Plaintiff cannot now state it did not receive that email as a basis for SCUTPA liability.

ELECTRONICALLY FILED - 2025 May 02 8:37 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP100379

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Further, the findings in the Order also preempt liability based on representations about insurance coverage. The Order finds that Plaintiff was on notice as of January 2019 of the need to seek payment from private health insurance, and that Defendants did not intend to protect any claims to insurance proceeds—*after* the statement about insurance proceeds and before any further letter of protection. Also, the Order finds Plaintiff was aware as of April 29, 2019, that the additional policy had a subrogation requirement and required filing with private health insurance first. According to the Order, Plaintiff had no right to rely on statements about coverage, the statement about insurance coverage was only an opinion, and Plaintiff needed to perform its own due diligence about the referenced policies and seek confirmations of coverage from the carriers before surgery.

It cannot be unfair and deceptive to make a statement of opinion on insurance limits that caused Plaintiff to provide services, when Plaintiff knew to seek payment from private health insurance instead of proceeding under a letter of protection or assignment immediately after the statement about limits, that Plaintiff agreed to, and Plaintiff had no right to rely on the statement. Therefore, this Court grants Defendants summary judgment on Plaintiff's claim for SCUTPA violation.

3. Plaintiff's claims for negligent misrepresentation and promissory estoppel are preempted by the findings in the Order.

Plaintiff alleges in the negligent misrepresentation claim that Defendants made false representations, and Plaintiff justifiably relied on those representations. Plaintiff alleges in its promissory estoppel claim that Defendants gave an "unambiguous promise" and assurances about "the availability of over $1 million in insurance coverage" and that Plaintiff reasonably relied on that promise. Reasonable reliance, of course, is an element of both claims. *See West v. Gladney*, 341 S.C. 127, 134, 533 S.E.2d 334, 337 (Ct. App. 2000) (listing the elements of negligent representation and including "the defendant owed a duty of care to see that he

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communicated truthful information to the plaintiff," "the plaintiff justifiably relied on the representation," and explaining reliance must be reasonable (quoting *AMA Management Corp. v. Strasburger*, 309 S.C. 213, 222, 420 S.E.2d 868, 874 (Ct. App. 1992));*Woods v. State*, 314 S.C. 501, 505, 431 S.E.2d 260, 263 (Ct. App. 1993) (including as element of promissory estoppel "reasonable reliance upon the promise by the party to whom the promise is made).

The findings in the Order, however, preempt any arguments that Plaintiff justifiably or reasonably relied on statements about coverage because the Order states Plaintiff did not have a right to rely on representations about coverage. Order, ¶ 48, ¶ 57. Further, the findings in the Order recognize Plaintiff had a duty to use reasonable diligence to discover the truth of the representations about coverage. Order, ¶ 48; ¶ 56. In addition, the Order finds the statement about insurance coverage was an opinion and, therefore, not a statement of fact. Because these rulings are the law of the case, but Plaintiff would need to prove the opposite to succeed on claims for negligent misrepresentation and promissory estoppel, the claims are preempted by the Order and this Court grants Defendants summary judgment on those claims.

II. Plaintiff cannot prove the necessary elements of breach of contract because, as a matter of law, there was no legally enforceable contract between Plaintiff and Defendants.

Initially, Plaintiff alleged the contract was based on the Letters of Protection. Then Plaintiff alleged in its Second Amended Complaint that it entered into a contract with Defendants wherein it "would provide medical services to the Lawyers' client based on the Lawyers' representations about coverage." In its memorandum in opposition to summary judgment, Plaintiff argued there is a genuine issue of material fact whether the agreement included an implied term about the availability of coverage. Defendants argued there was no contract because Defendants did not offer to pay for Client's medical bills if Plaintiff treated Client, and Plaintiff did not accept by providing medical services conditioned on a promise to pay the bills. This Court agrees with Defendants.

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To succeed on a breach of contract claim a plaintiff must establish (1) the existence of a contract; (2) its breach; and (3) the damages caused by the breach. *Branche Builders, Inc. v. Coggins*, 386 S.C. 43, 48, 686 S.E.2d 200, 202 (Ct. App. 2009). "The general rule is that for a breach of contract the [breaching party] is liable for whatever damages follow as a natural consequence and a proximate result of such breach." *S. Glass & Plastics Co. v. Kemper*, 399 S.C. 483, 492, 732 S.E.2d 205, 209 (Ct. App. 2012) (quoting *Fuller v. E. Fire & Cas. Ins. Co.*, 240 S.C. 75, 89, 124 S.E.2d 602, 610 (1962)).

"The necessary elements of a contract are an offer, acceptance, and valuable consideration." *Sauner v. Pub. Serv. Auth. of S.C.*, 354 S.C. 397, 406, 581 S.E.2d 161, 166 (2003). "An offer is the manifestation of willingness to enter into a bargain, so made as to justify another person in understanding that his assent to that bargain is invited and will conclude it." *Carolina Amusement Co. v. Connecticut Nat'l Life Ins. Co.*, 313 S.C. 215, 437 S.E.2d 122 (Ct. App. 1993) (quoting Restatement (Second) of Contracts § 24 (1981)). A valid offer "identifies the bargained for exchange and creates a power of acceptance in the offeree." *Id.* "To be binding, an offer must be definite. *Prescott v. Farmers Tel. Co-op., Inc.*, 335 S.C. 330, 336–37, 516 S.E.2d 923, 926 (1999). Also, it must "be one which is intended of itself to create legal relations on acceptance." *Id.*(quoting *McLaurin v. Hamer*, 165 S.C. 411, 420, 164 S.E. 2, 5 (1932)).

"Acceptance of an offer is a manifestation of assent to the terms thereof made by the offeree in a manner invited or required by the offer." *Electro-Lab of Aiken, Inc. v. Sharp Constr. Co. of Sumter*, 357 S.C. 363, 369, 593 S.E.2d 170, 173 (Ct. App. 2004) (quoting Restatement (Second) of Contracts § 50 (1981)). "A typical contract contains mutual promises and is created by an acceptance constituting a return promise by the offeree." *Id.* "Moreover, a contract only arises when there is an actual agreement by the parties in which the parties demonstrate a mutual intent to be bound." *Id.*

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Construing the facts and reasonable inferences in Plaintiff's favor, there is no genuine issue of material fact that there was no legally enforceable contract between Defendants and Plaintiff whereby Plaintiff agreed to provide medical services to Client in return for a promise on the availability of coverage, or that Defendants would be personally responsible for Client's medical bills.

The language in the Letters of Protection and the emails on insurance coverage did not include an offer that Defendants would pay for Client's medical costs. The December 20, 2018 letter stated the law firm agreed "protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident" and that the Client "has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance." Thus, prior to discussion of insurance coverage, Plaintiff was on notice of the potential of an insufficient recovery in settlement proceeds and that the agreement was limited to protection out of settlement proceeds received.

The January 21, 2019 emails did not include, or imply, a promise that Defendants agreed to be responsible for Client's medical costs. According to the medical bills, Plaintiff was already treating Client when it inquired about "limits" for the client on January 21, 2019. Defendants' paralegal explained she did not know the limits of the at-fault driver, but that Client had $100,000 in UIM coverage on a Safeco Policy and carried $1,000,000 in "Occupational Accident Coverage" on a One Beacon policy, and that Defendants were "not concerned that there will be enough over all coverage to pay the claim." However, hours later the same day, Defendants' paralegal informed Plaintiff that Defendants just learned that Client needed surgery and all of Client's treatment should be filed with his private health insurance company. Further, that it "would be best for everyone involved if we NOT do the treatment under an Assignment/Letter of Protection." Plaintiff's employee responded, "Okay thanks for the update."

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The language in the email referencing insurance coverage cannot be construed as an offer that Defendants would agree to pay for Client's medical bills out of that specific coverage. The language is not definite, and does not "identify the bargained for exchange" and create "a power of acceptance" in Plaintiff. The language does not contain a bargained for exchange identifying what Plaintiff is giving in exchange for insurance coverage representations. The language does not create a power of acceptance because it does not identify what Plaintiff would need to do (or refrain from doing) in order to accept. Without language identifying the bargained for exchange, there can be no contract. Also, without language identifying what Plaintiff would need to do to accept, there can be no offer and no contract.

In the context of the prior letter of protection explaining Client would be personally responsible in the event of an insufficient recovery, Plaintiff's Financial Policy reflecting the same language, that Plaintiff was already providing services to Client, and a retraction of any assignment or letter of protection mere hours after referencing insurance, there is no genuine issue of material fact and there was no offer.

Even if the statement about coverage could be construed as an offer, Plaintiff did not communicate any acceptance in the manner invited or required by the offer. The offer did not identify that Plaintiff could accept by providing treatment and, regardless, Plaintiff was already providing services to Client before the email exchange about coverage and Defendants' paralegal immediately contacted Plaintiff's employee about obtaining payment through insurance before any further services were rendered.

Ultimately, in order to find there was a contract, there would need to be a definite offer that Defendants agreed to be responsible for the medical bills if Plaintiff provided treatment to Client. The only reasonable inference is that Defendants did not offer to be responsible for Client's medical bills if Plaintiff agreed to provide medical services to Client, and Plaintiff did not accept that offer and provide medical service to Client based on that offer. Without that offer

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and acceptance, there is no contract, and this Court grants Defendants summary judgment on Plaintiff's breach of contract claim.

III. Defendants did not violate the South Carolina Unfair Trade Practices Act because Defendants were not engaged in a "trade or commerce" with Plaintiff.

Defendants argued, among other things, that this Court should grant summary judgment because Defendants were not engaged in trade or commerce with Plaintiff. Plaintiff argued this Court should deny summary judgment "because there are disputes on whether the Defendants' suspect 'email' attempting to alter the record on what was communicated about the Letters of Protection constitute unfair or deceptive acts." This Court agrees with Defendants.

SCUTPA makes unlawful "unfair or deceptive acts or practices in the conduct of any trade or commerce." S.C. Code Ann. § 39-5-20(a). To state a claim under SCUTPA, a plaintiff must show "(1) the defendant engaged in an unfair or deceptive act in the conduct of trade or commerce; (2) the unfair or deceptive act affected [the] public interest; and (3) the plaintiff suffered monetary or property loss as a result of the defendant's unfair or deceptive act(s)." *Health Promotion Specialists, LLC v. S.C. Bd. of Dentistry*, 403 S.C. 623, 638, 743 S.E.2d 808, 816 (2013) (quoting *Wright v. Craft*, 372 S.C. 1, 23, 640 S.E.2d 486, 498 (Ct. App. 2006)).

Under the Act, "trade or commerce" includes "the advertising, offering for sale, sale or distribution of any services and any property, tangible or intangible, real, personal or mixed, and any other article, commodity or thing of value wherever situate." S.C. Code Ann. § 39-5-10(b). These terms make clear the Act applies "to business and consumer transactions." *Health Promotion Specialists, LLC*, 403 S.C. at 638, 743 S.E.2d at 816 (2013). "Furthermore, by its very definition, 'trade or commerce' involves ''[e]very business occupation carried on for subsistence or profit and involving the elements of bargain and sale, barter, exchange, or traffic." *Id.* (quoting *Black's Law Dictionary* (9th ed. 2009)). For example, our supreme court determined the Board of Dentistry was not engaged in trade or commerce under the act when it

promulgated a regulation because it was not involved in the "advertisement, sale, or distribution of services or property within a business context." *Health Promotion Specialists, LLC*, 403 S.C. at 639, 743 S.E.2d at 816. The court also discussed how the act can apply to professional services, which the regulation governed, but it still was not within the ambit of SCUTPA because it did not involve the sale of those services. *Id.* at 639 n.13, 743 S.E.2d at 816 n.13.

Construing the facts and reasonable inferences in Plaintiff's favor, there is no genuine issue of material fact that Defendants were not engaged in trade or commerce with Plaintiff in a business context when the representations were made. Defendants were not selling professional services to Plaintiff, and the communication were not related to the "advertisement, sale, or distribution of services or property" to Plaintiff. Plaintiff gave nothing in response to the representations. Because Defendants were not engaged in trade or commerce with Plaintiff when the representations occurred, Plaintiff's SCUTPA claim fails, and this Court grants Defendants summary judgment on that claim.

IV. Plaintiff cannot prove the necessary elements of negligent misrepresentation because Plaintiff cannot establish Defendants made a false statement to Plaintiff or that Plaintiff actually relied on those statements.

Defendants argue there is no genuine issue of material fact and summary judgment is appropriate, because they did not make a false statement of fact regarding insurance to Plaintiff or that Plaintiff actually relied on any statements of Defendants. Plaintiff argues there are genuine issues of material fact on every element of its negligent misrepresentation claim, specifically that "Defendants made statements about insurance coverage that were either inaccurate or inadequately investigated." Further, Plaintiff argues there is evidence that Carolina Neurosurgery reasonably relied on Defendants' representations about insurance coverage. This Court agrees with Defendants.

To prevail on a cause of action for negligent misrepresentation as it relates to a pecuniary loss, a plaintiff must prove: (1) the defendant made a false representation to the plaintiff; (2) the

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defendant had a pecuniary interest in making the statement; (3) the defendant owed a duty of care to see that he communicated truthful information to the plaintiff; (4) the defendant breached that duty by failing to exercise due care; (5) the plaintiff justifiably relied on the representation; and (6) the plaintiff suffered a pecuniary loss as a result of his reliance upon that representation. *Ama Management Corp v. Strasburger*, 309 S.C. 213, 420 S.E.2d 868 (1992). For the tort of negligent misrepresentation, "the element of 'false misrepresentation' cannot be premised upon an omission or silence of a party." *Allegro, Inc. v. Scully*, 409 S.C. 392, 419, 762 S.E.2d 54, 68 (Ct. App. 2014), *rev'd in part on other grounds*, 418 S.C. 24, 791 S.E.2d 140 (2016).

Construing the facts and inferences in the light most favorable to Plaintiff, there is no genuine issue of material fact and Defendants did not make an affirmative misrepresentation of fact to Plaintiff. Plaintiff takes issue with Defendants' paralegal mentioning the insurance policies in response to Plaintiff's employee inquiring about limits. The statements Defendants' paralegal made in the email were not false. Defendants' employee replied to Plaintiff's employee's email, telling Plaintiff's employee she did not know what the at-fault party's liability insurance was—a true statement. Defendants' employee stated that Client "carried" a policy with Safeco with $100,000 in UIM and One Beacon Policy for "Occupational Accident Coverage" for $1,000,000—a true statement that remained true. Client had those policies in effect when Defendants' paralegal communicated with Plaintiff's employee. In addition, Defendants' paralegal mentioned that they were "not concerned that there will be enough overall coverage to pay the claim." This statement was true at the time made and only an opinion about their concern about coverage.

Further, even though Defendants' employee said they were "not concerned", she followed up that same day after she found out that Client needed surgery, explaining to Plaintiff's employee that all of Client's surgical treatment was to be filed with his private health insurance company, and that the treatment should not proceed under an assignment or Letter of

Protection. As Defendants testified, this shows that Defendants were concerned about coverage. Thus, Plaintiff knew after any statements about policies, that it was to process payment through the private health insurer—not the UIM policy or occupational policy limits. Also, Plaintiff's employee responded to Defendants' paralegal's request to submit claims to insurance, saying "Okay thanks for the update." Moreover, during Plaintiff's lawsuit, One Beacon's successor accepted coverage and paid an amount for each of Plaintiff's services provided Client according to the Explanation of Benefits, albeit at a reduced amount. Thus, it would be true that Client's One Beacon policy provided coverage. Because there is no genuine issue of material facts that the statements on which Plaintiff relies for its negligent misrepresentation were true when made, there is no false statement, and this Court finds summary judgment appropriate.

Additionally, there is no genuine issue of material fact that Plaintiff did not actually rely on any of Defendants' representations to provide services to Client. Plaintiff has a financial policy that said the Client was responsible for the bill and Dr. Highsmith testified he relies on that financial policy. Dr. Highsmith also testified that coverages do not affect his treatment recommendation. Moreover, Dr. Highsmith testified that he did not know whether he saw the email from Defendants' paralegal referencing insurance policies prior to providing services to Client, and further that the substance of the emails about coverage were not relevant to Client's medical care. He also testified that, in a situation where a patient needs surgery and he doesn't know anything about what insurance coverage is, he would still provide the surgery; and Client needed the surgery.

Even construing the evidence and reasonable inferences in Plaintiff's favor, the only reasonable inference from the evidence is that the statements Plaintiff takes issues with were true and that Plaintiff did not actually, reasonably, or justifiably rely on statements about insurance coverage to provide medical care to Client. Accordingly, this Court grants Defendants summary judgment on Plaintiff's negligent misrepresentation claim.

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V. Plaintiff cannot prove the necessary elements for promissory estoppel because there is no evidence that Defendants made an unambiguous promise that insurance coverages would be available to pay for Client's medical bills.

Defendants argued that summary judgment is appropriate on Plaintiff's claim for promissory estoppel because there is no evidence of any unambiguous promise to pay for Client's medical bills out of specific insurance coverages if Plaintiff provided Client services. Plaintiff did not directly address this argument in its memorandum or at the hearing. This Court agrees with Defendants.

"The elements of promissory estoppel are:

> (1) the presence of a promise unambiguous in its terms; (2) reasonable reliance upon the promise by the party to whom the promise is made; (3) the reliance is expected and foreseeable by the party who makes the promise; and (4) the party to whom the promise is made must sustain injury in reliance on the promise.

Rushing v. McKinney, 370 S.C. 280, 295, 633 S.E.2d 917, 925 (Ct. App. 2006) (quoting *Woods v. State,* 314 S.C. 501, 505, 431 S.E.2d 260, 263 (Ct. App. 1993)).

Construing the facts and reasonable inferences in Plaintiff's favor, there is no genuine issue of material fact that Defendants did not make an unambiguous promise to pay for Clients medical bills out of specific coverages. In its Complaint, Plaintiff alleged Defendants "made [an] unambiguous promise and gave unambiguous assurances to [Plaintiff] concerning the availability of over $1 million in insurance coverage for the medical services [Plaintiff] was to provide to" the Client.

The email on which Plaintiff relies, however, does not contain an unambiguous promise that the insurance proceeds would be available to pay for the medical services. In the email, Defendants' employee stated that Client "carried" a policy with Safeco with $100,000 in UIM and One Beacon Policy for "Occupational Accident Coverage" for $1,000,000. Those statements were truthful representations of the policies Client had. In addition, Defendants' paralegal stated they were "not concerned that there will be enough overall coverage to pay the

claim." Bennett's statement that *she was not concerned* about coverage is not tantamount to an unambiguous promise that those coverages were available to pay for Plaintiff's medical services. Further, Defendants' paralegal responded again to Plaintiff's employee two hours later after she discovered the Client needed surgery, and told Plaintiff to bill Client's health insurance, and that it would be better not to provide services under an assignment or letter of protection. Plaintiff's employee agreed. Because there is no genuine issue of material fact that there was no unambiguous promise that coverages would pay for Plaintiff's services, this Court grants Defendants summary judgment on Plaintiff's promissory estoppel claim.

ORDERED, ADJUDGED, and DECREED that Defendants' Motion for Summary Judgment is hereby GRANTED.

_____

The Honorable Jessica A. Salvini
Presiding Judge, Ninth Judicial Circuit

Charleston, South Carolina

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Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Summary Judgment

So Ordered

Jessica A. Salvini

ELECTRONICALLY FILED - 2025 May 08 3:36 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT
Carolina Neurosurgery & Orthopedics, Inc., Plaintiff,	)	
vs.	)	INITAL ORDER REGARDING MOTION TO RECONSIDER
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP, Defendants.	)	Case No.: 2021-CP-10-03379

A Rule 59 (e) SCRCP motion to reconsider and to alter or amend has been filed with the Court on April 14, 2025, and was served on the Court on April 17, 2025. Pursuant to Rule 59(f), SCRCP, the Court, in its discretion, may decide this motion based on briefs without oral argument. The Court will decide this motion on written submissions. Written submissions are not required by the non-moving party, but will be considered. The moving party may rely upon what has been filed or may supplement.

No additional briefs are required and Counsel may rely the current record, however the deadline to file written submissions **from the movant regarding this motion is 4:00 PM on Thursday, May 15, 2025.** Any submissions in **reply must be filed by 4:00 p.m. on Thursday, May 22, 2025.** A copy of any documents filed must be forwarded immediately to the undersigned judge and to opposing counsel. The copies to the judge shall be sent via US Postal Service to 305 E. North Street, Greenville, SC 29601, and/or by electronic mail to jsalvinisc@sccourts.org and jsalvinilc@sccourts.org.

AND IT IS SO ORDERED.

Presiding Judge's Signature Page to Follow.

ELECTRONICALLY FILED - 2025 May 08 3:36 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Other

So Ordered

Jessica A. Salvini

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF Charleston
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2021CP1003379

Carolina Neurosurgery & Orthopedics Inc
PLAINTIFF(S)

Michael A Maucher et al
DEFENDANT(S)

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT**. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☑ **DECISION BY THE COURT**. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☑ Statement of Judgment by the Court:

This matter is before the Court by way of Defendants' Motion for Sanctions filed on May 12, 2025. After reviewing the motion and the record, the Court declines to hold a hearing. Defendants' Motion for Sanctions is denied.

IT IS SO ORDERED.

ORDER INFORMATION

This order ☐ ends ☑ does not end the case. ☐ See Page 2 for additional information.

For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 06/18/2025 .

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

ELECTRONICALLY FILED - 2025 Jun 18 4:17 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Court Reporter:

E-Filing Note: The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

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ELECTRONICALLY FILED - 2025 Jun 18 4:17 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Electronic Form 4

So Ordered

Jessica A. Salvini

ELECTRONICALLY FILED - 2025 Jul 14 10:04 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT
Carolina Neurosurgery & Orthopedics, Inc., Plaintiff, vs. Michael A. Maucher, Esq. and DeLuca & Maucher, LLP, Defendants.	)	INITAL ORDER REGARDING MOTION TO RECONSIDER Case No.: 2021-CP-10-03379

A Rule 59 (e) SCRCP motion to reconsider and to alter or amend has been filed with the Court on June 30, 2025, and was served on the Court on June 30, 2025. Pursuant to Rule 59(f), SCRCP, the Court, in its discretion, may decide this motion based on briefs without oral argument. The Court will decide this motion on written submissions. Written submissions are not required by the non-moving party, but will be considered. The moving party may rely upon what has been filed or may supplement.

No additional briefs are required and Counsel may rely the current record, however the deadline to file written submissions **from the movant regarding this motion is 4:00 PM on Monday, July 21, 2025.** Any submissions in **reply must be filed by 4:00 p.m. on Monday, July 28, 2025.** A copy of any documents filed must be forwarded immediately to the undersigned judge and to opposing counsel. The copies to the judge shall be sent via US Postal Service to 305 E. North Street, Greenville, SC 29601, and/or by electronic mail to jsalvinisc@sccourts.org and jsalvinilc@sccourts.org.

AND IT IS SO ORDERED.

Presiding Judge's Signature Page to Follow.

ELECTRONICALLY FILED - 2025 Jul 14 10:04 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Other

So Ordered

Jessica A. Salvini

ELECTRONICALLY FILED - 2025 Jun 09 10:21 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT
Carolina Neurosurgery & Orthopedics, Inc., Plaintiff, vs. Michael A. Maucher, Esq. and DeLuca & Maucher, LLP, Defendants.	)	FINAL ORDER REGARDING MOTION TO RECONSIDER Case No.: 2021-CP-10-03379

A Rule 59(e), SCRCP motion to reconsider and to alter or amend has been received, filed with the Court on April 14, 2025, and served on the Court on April 17, 2025. The Motion to Reconsider was properly served on the Court per Rule 59(g), SCRCP. As previously explained to Counsel, pursuant to Rule 59(f), SCRCP, the Court, in its discretion, may decide the motion based on briefs without oral argument. The Court indicated to the parties by prior order in the Initial Order Regarding Motion for Reconsideration that it would decide the issues on written submissions. Further, the Court informed the parties that written submissions were not required by the non-moving party, and that the moving party could rely upon its filings or supplement. The deadlines to file written submissions regarding these motions has now passed.

After careful consideration of the able arguments and filings of Counsel and review of the record, the Court is unable to discover any material fact or principle of law that either has been overlooked or disregarded and further finds no error of law or fact not appropriately considered.

Accordingly, the Motion for Reconsideration made pursuant to Rule 59, SCRCP, [1] is respectfully DENIED.

AND IT IS SO ORDERED.

Presiding Judge's Signature Page to Follow.

[1] The Court, in its discretion, has determined this Motion on the filings, without oral argument, pursuant to Rule 59(f), SCRCP.

ELECTRONICALLY FILED - 2025 Jun 09 10:21 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Other

So Ordered

Jessica A. Salvini

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF Charleston
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2021CP1003379

Carolina Neurosurgery & Orthopedics Inc
PLAINTIFF(S)

Michael A Maucher et al
DEFENDANT(S)

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT**. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☑ **DECISION BY THE COURT**. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☑ Statement of Judgment by the Court:

This matter is before the Court by way of Defendants' Motion for Sanctions filed on May 12, 2025. After reviewing the motion and the record, the Court declines to hold a hearing. Defendants' Motion for Sanctions is denied.

IT IS SO ORDERED.

ORDER INFORMATION

This order ☐ ends ☑ does not end the case. ☐ See Page 2 for additional information.

For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 06/18/2025 .

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

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Court Reporter:

E-Filing Note: The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

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Jessica A. Salvini

ELECTRONICALLY FILED - 2025 Jul 14 10:04 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT
Carolina Neurosurgery & Orthopedics, Inc., Plaintiff,	)	
vs.	)	INITAL ORDER REGARDING MOTION TO RECONSIDER
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP, Defendants.	)	Case No.: 2021-CP-10-03379

A Rule 59 (e) SCRCP motion to reconsider and to alter or amend has been filed with the Court on June 30, 2025, and was served on the Court on June 30, 2025. Pursuant to Rule 59(f), SCRCP, the Court, in its discretion, may decide this motion based on briefs without oral argument. The Court will decide this motion on written submissions. Written submissions are not required by the non-moving party, but will be considered. The moving party may rely upon what has been filed or may supplement.

No additional briefs are required and Counsel may rely the current record, however the deadline to file written submissions **from the movant regarding this motion is 4:00 PM on Monday, July 21, 2025.** Any submissions in **reply must be filed by 4:00 p.m. on Monday, July 28, 2025.** A copy of any documents filed must be forwarded immediately to the undersigned judge and to opposing counsel. The copies to the judge shall be sent via US Postal Service to 305 E. North Street, Greenville, SC 29601, and/or by electronic mail to jsalvinisc@sccourts.org and jsalvinilc@sccourts.org.

AND IT IS SO ORDERED.

Presiding Judge's Signature Page to Follow.

ELECTRONICALLY FILED - 2025 Jul 14 10:04 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Charleston Common Pleas

Case Caption: Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al

Case Number: 2021CP1003379

Type: Order/Other

So Ordered

Jessica A. Salvini

ELECTRONICALLY FILED - 2025 Aug 25 11:11 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT
Carolina Neurosurgery & Orthopedics, Inc., Plaintiff,	)	
vs.	)	FINAL ORDER REGARDING MOTION TO RECONSIDER
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP, Defendants.	)	Case No.: 2021-CP-10-03379

A Rule 59(e), SCRCP motion to reconsider and to alter or amend has been received, filed with the Court on June 30, 2025, and was served on the Court on June 30, 2025. As previously explained, pursuant to Rule 59(f), SCRCP, the Court, in its discretion, may decide the motion based on briefs without oral argument. The Court indicated to the parties by prior order in the Initial Order Regarding Motion for Reconsideration that it would decide the issues on written submissions. Further, the Court informed the parties that written submissions were not required by the non-moving party, and that the moving party could rely upon its filings or supplement. The deadlines to file written submissions regarding these motions have now passed.

After careful consideration of the able arguments and filings of Counsel and review of the record, the Court is unable to discover any material fact or principle of law that either has been overlooked or disregarded and further finds no error of law or fact not appropriately considered.

Accordingly, the Motion for Reconsideration made pursuant to Rule 59, SCRCP, [1] is respectfully DENIED.

AND IT IS SO ORDERED.

Presiding Judge's Signature Page to Follow.

[1] The Court, in its discretion, has determined this Motion on the filings, without oral argument, pursuant to Rule 59(f), SCRCP.

ELECTRONICALLY FILED - 2025 Aug 25 11:11 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Other

So Ordered

Jessica A. Salvini

ELECTRONICALLY FILED - 2021 Jul 22 2:24 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-------
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP Defendants.	**SUMMONS**

TO: THE DEFENDANTS ABOVE NAMED:

YOU ARE HEREBY SUMMONED and required to answer the Verified Complaint, a copy of which is served upon you, and to serve a copy of your Answer to the Verified Complaint on the Plaintiff's attorney within (30) days after the service hereof, exclusive of the day of such service, and if you fail to answer the Verified Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Verified Complaint.

PENDARVIS LAW OFFICES, P.C.

/s/ Thomas A. Pendarvis
Thomas A. Pendarvis (SC Bar #64918)
Christopher W. Lempesis, Jr. (SC Bar #77012)
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Counsel for Plaintiff

Beaufort, South Carolina

July 22, 2021

ELECTRONICALLY FILED - 2021 Jul 22 2:24 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-------
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP Defendants.	**VERIFIED COMPLAINT** **(Jury Trial Demanded)** 1. Breach of Contract 2. Breach of Contract Accompanied by a Fraudulent Act 3. Violation SC Unfair Trade Practices Act 4. Fraud 5. Constructive Fraud 6. Unjust Enrichment 7. Negligence

Plaintiff, CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., complaining of Defendants, Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, respectfully shows unto the Court:

SUMMARY OF THE CASE

1. This case arises from Defendants' false or inaccurate representations about the availability of liability and homeowners' insurance coverage available to cover medical and surgical expenses for one of Defendants' clients and Defendants' promises in a letter of protection, the combination of which led CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., and its surgeon, Dr. Highsmith, and their staff to perform over $125,000 in surgery and related healthcare services for Defendants' client when, contrary to Defendants' representations, there was no available insurance coverage, and then to make things worse, Defendants disregarded the promises in letter of protection when Defendants remitted no funds to Dr. Highsmith after their client settled the client's tort claim.

PARTIES

2. Plaintiff, CAROLINA NEUROSURGERY & ORTHOPEDICS, INC. ("CAROLINA

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NEUROSURGERY"), is a citizen and resident of Charleston County, South Carolina, who is licensed to practice medicine in South Carolina. CAROLINA NEUROSURGERY's primary surgeon is Jason M. Highsmith, M.D. Reference in the Complaint to CAROLINA NEUROSURGERY includes reference to Dr. Highsmith unless otherwise distinguished.

3. Defendant, Michael A. Maucher, Esq. ("Mr. Maucher"), is, upon information and belief, a citizen and resident of Charleston County, South Carolina.

4. Defendant, DELUCA & MAUCHER, LLP ("the Law Firm"), is, upon information and belief, a South Carolina Limited Liability Corporation operating as a law practice with offices in Charleston County, South Carolina. (Mr. Maucher and the Law Firm will be referred to collectively as "the Lawyers".)

JURISDICTION

5. This Court has jurisdiction based upon Article V of the South Carolina Constitution, S.C. CODE ANN. §§ 36-2-802 and 36-2-803, and its plenary powers.

VENUE

6. Venue is proper in Charleston County because, upon information and belief, Mr. Maucher resides in Charleston County, the Lawyers' principal offices are in Charleston County, and the acts and omissions complained of occurred in Charleston County, South Carolina.

FACTS

7. On December 14, 2018, an individual identified in this Verified Complaint as "the Lawyers' client" was injured in a motor vehicle collision. The Lawyers' client was a prior patient of CAROLINA NEUROSURGERY, and its surgeon, Dr. Highsmith, and had a procedure with Dr. Highsmith in the past.

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8. After December 14, 2018, the Lawyers requested the medical records from CAROLINA NEUROSURGERY specifically requesting the office provide all medical records available that documented the additional elective treatments related to this current date of loss and prior medical records for the Lawyers' client's collision-related injuries.

9. From the outset, the Lawyers were aware CAROLINA NEUROSURGERY's surgeon, Dr. Highsmith, operates his medical practice separate from CENTER FOR ADVANCED SURGERY, LLC, which is an entity providing healthcare services where Dr. Highsmith sometimes perform surgery.

10. From the outset, the Lawyers were aware CAROLINA NEUROSURGERY's invoices for medical/surgical services are billed separately from those built by CENTER FOR ADVANCED SURGERY, LLC.

11. On December 20, 2018, the Lawyers sent CAROLINA NEUROSURGERY a "Letter of Protection" ("the 1st LOP") promising to "protect *any claim* which you may have out of any settlement proceeds we may receive arising of the incident referred to above" to secure payment for all future treatment expenses out of liability insurance proceeds providing coverage for the Lawyers' client's claims. (Lawyers' first letter of protection, dated December 20, 2018, filed as "**Exhibit 1**.")

12. On January 3, 2019, based on the Lawyers' representations and the 1st LOP, CAROLINA NEUROSURGERY offered to treat the Lawyers' client's collision-related injuries through all elective treatments, under CAROLINA NEUROSURGERY's "Financial Policy." (Financial Policy filed as "**Exhibit 2**.")

13. The Lawyers' client accepted the contract terms CAROLINA NEUROSURGERY offered in and related to the "Financial Policy," as indicated by his signature of that document.

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14. At the time of the Lawyers' client's signature and thereafter, all involved parties including the Lawyers' client, the Lawyers, and CAROLINA NEUROSURGERY, knew a) CAROLINA NEUROSURGERY and its' surgeon, Dr. Highsmith were an "out-of-network" healthcare providers for the Lawyers' client and b) CAROLINA NEUROSURGERY was offering to provide elective medical/surgical services for the Lawyers' client.

15. Because the Lawyers' client did not have in-network health insurance coverage for any treatments provided by CAROLINA NEUROSURGERY, payment for services fell under the second bullet point of CAROLINA NEUROSURGERY's "Financial Policy", "IF YOU DO NOT HAVE INSURANCE:"

> *Our policy requires payment in full today, unless, other arrangements are made. If you cannot pay in full now, we request partial payment today as you arranged for credit on your account with a payment plan agreement with our credit and collection manager.*

(See Exhibit 2.)

16. At this time, based on representations of the Lawyers and the 1st LOP, "other arrangements" had been made such that CAROLINA NEUROSURGERY would collect the full value of the Lawyers' client's elective treatments from the funds the Lawyers represented would be provided by various liability insurance policies that would cover the Lawyers' client's personal injury claims in an amount over $1,100,000.

17. In January 2019, CAROLINA NEUROSURGERY, Dr. Highsmith, and their staff started providing the Lawyers' client's elective treatments. (See "Statement" dated November 2, 2020, filed as "**Exhibit 3**.")

18. On January 16, 2019, after surgery was recommended, CAROLINA NEUROSURGERY, Dr. Highsmith, and their staff requested written confirmation of the limits

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of coverage that would fund additional expenses for elective treatment to be provided to the Lawyers' client. (See email thread, dated Jan. 16 – 21, 2019, filed as "**Exhibit 4**.")

19. On January 21, 2019 at 9:24 am, the Lawyers responded, indicating there were no concerns regarding liability insurance coverage in that there were liability insurance policies in place providing over $1,100,000 in coverage for expenses occasioned by treatment being provided by CAROLINA NEUROSURGERY, Dr. Highsmith, and their staff. (See Defendants' email dated Jan. 21, 2019 at 9:24 am, "Exhibit 4.")

20. On January 21, 2019, at 11:58:35 AM, the Lawyers sent a second email **discussing pre-existing injuries** and indicating that they preferred that treatment not be provided under their 1st LOP. (See Defendants' email dated Jan. 21, 2019 at 11:58 am, "**Exhibit 5**.")

21. The Lawyers never explained to CAROLINA NEUROSURGERY, Dr. Highsmith, or their staff there were concerns regarding insurance coverage.

22. On March 7, 2019, the Lawyers forwarded a second Letter of Protection ("the LOP") by email wherein the Lawyers agreed "to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above." (See Defendants' email dated, March 7, 2019, forwarding the LOP, filed as "**Exhibit 6**.")

23. Within the email forwarding the Letter of Protection, the Lawyers recited:

> *Please see attached LOP.* ***This LOP covers whatever is NOT paid by private health insurance.***

24. In the LOP, the Lawyers made an "agreement to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above." (See Exhibit 6.)

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25. The Lawyers made no communications to CAROLINA NEUROSURGERY, Dr. Highsmith, or their staff before Dr. Highsmith performed the first and second surgeries on the Lawyers' client to explain that the available insurance coverage was less than the $1,100,000 mentioned in the Lawyers' January 21, 2019 email or that they would not honor the LOP.

26. On March 15, 2019, CAROLINA NEUROSURGERY, Dr. Highsmith, and their staff, relying on the Lawyers' representations of insurance coverage and the LOP, performed surgery on the Lawyers' client.

27. On March 19, 2019, CAROLINA NEUROSURGERY emailed the Lawyers a copy of the "Operative Report" from the March 15 surgery. (This email is filed as "**Exhibit 7**.")

28. On April 26, 2019, the Lawyers' client signed and provided CAROLINA NEUROSURGERY a form stating: "✓ **I do not have Health Insurance at this time**". (Health Insurance Verification Form, filed as "**Exhibit 8**.")

29. On April 29, 2019, at 11:20 am, the Lawyers sent CAROLINA NEUROSURGERY an email stating:

> Because the at-fault party only had $30,000.00, and [the Lawyers' client]'s Underinsured Motorist Coverage does not apply, ALL of the treatment [the Lawyers' client] has received (and will continue to receive) must be filed under his private health insurance. We cannot honor anymore treatment under a Letter of Protection. Please note [the Lawyers' client]'s file accordingly.

(See Lawyers' email dated Apr. 29, 2019, filed as "**Exhibit 9**.")

30. On April 30, 2019, CAROLINA NEUROSURGERY emailed the Lawyers notes and billing ledgers from the Lawyers' client's April 26, 2019, follow-up visit. (Notes and billing ledgers; "**Exhibit 10**.")

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31. On May 2, 2019, CAROLINA NEUROSURGERY, relying on the Lawyers' promises and assurances on the amount of other insurance coverage and the Lawyers' promises and assurances in the LOP they would pay "whatever is NOT paid by private health insurance," performed additional surgery on the Lawyers' client at an approximate cost of $65,000. (Notes and billing ledgers, p. 6; Exhibit 10.)

32. On May 6, 2019, CAROLINA NEUROSURGERY emailed the Lawyers the Operating Report from the May 2, 2019 surgery. (Operating Report, filed as "**Exhibit 11**.")

33. The final invoice for the additional elective treatments CAROLINA NEUROSURGERY provided the Lawyers' client through December 20, 2019, is $125,409.25. (Exhibit 3.)

34. The Lawyers have refused to pay the outstanding balance of $125,409.25.

35. Although the Lawyers claimed the total recovery for the Lawyers' client from liability insurance coverage was only $30,000, the Lawyers refused to pay CAROLINA NEUROSURGERY any portion of the $30,000.

36. The Lawyers' client has made no payments to CAROLINA NEUROSURGERY for the medical/surgical services CAROLINA NEUROSURGERY provided.

37. The Lawyers' representations to CAROLINA NEUROSURGERY there was $1,100,000 in insurance coverage for the Lawyers' client and that they would pay "whatever is NOT paid by private health insurance" were false.

38. The Lawyers now claim CAROLINA NEUROSURGERY should have submitted their invoices to the health insurance carrier for the Lawyers' client, even though they know or should know CAROLINA NEUROSURGERY is and was an out-of-network healthcare provider to whom the health insurance carrier for the Lawyers' client had no obligation to

pay under the health insurance policy at issued to the Lawyer's client.

39. The Lawyers have no explanation on why they have not paid CAROLINA NEUROSURGERY the entire $30,000 from the recovery obtained for the Lawyers' client.

FOR A FIRST CAUSE OF ACTION
(Breach of Contract)

40. CAROLINA NEUROSURGERY realleges and incorporates the foregoing factual and jurisdictional statements by reference as if they were set forth herein.

41. CAROLINA NEUROSURGERY and the Lawyers entered into a contract described earlier as the LOP.

42. CAROLINA NEUROSURGERY fulfilled all necessary preconditions, if any, of the LOP.

43. The Lawyers breached the LOP.

44. As a direct and proximate cause of the Lawyers' multiple or singular breach of the LOP, CAROLINA NEUROSURGERY sustained actual, consequential and incidental damages in an amount to be determined by the jury at the trial of this case.

45. Under the LOP, CAROLINA NEUROSURGERY also requests all fees and costs generated in pursue of the relief claimed, including but not limited to legal fees.

37. WHEREFORE, CAROLINA NEUROSURGERY demands judgment and an award against the Lawyers for actual damages, consequential damages, pre-judgment interest, court costs; and such other and further relief the Court deems just and proper.

FOR A SECOND CAUSE OF ACTION
(Breach of Contract Accompanied by a Fraudulent Act)

38. The foregoing factual and jurisdictional allegations are reiterated and realleged as though set forth verbatim.

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39. The Lawyers and CAROLINA NEUROSURGERY entered the LOP, with all parties knowing the availability of liability or other insurance coverage was a material term that must have been met as part of CAROLINA NEUROSURGERY's willingness and obligation to provide surgical services to the Lawyers' client, as contemplated within the LOP.

40. The Lawyers and CAROLINA NEUROSURGERY entered the LOP and provided surgical services, with all parties knowing the Lawyers had promised and assured CAROLINA NEUROSURGERY there was $1,100,000 in insurance coverage available to the Lawyers' client and with all parties knowing the Lawyers had made promises and assurances in the LOP they would pay "whatever is NOT paid by private health insurance."

41. The Lawyers breached the contract by falsely stating the amount of insurance coverage available to the Lawyers' client and falsely stating they would pay "whatever [wa]s NOT paid by private health insurance" for the Lawyers' client.

42. The Lawyers induced CAROLINA NEUROSURGERY to provide medical/surgical services to the Lawyers' client based on false and inaccurate representations about the amount of insurance coverage available and false and inaccurate representations about their intent to pay "whatever is NOT paid by private health insurance."

43. Before CAROLINA NEUROSURGERY provided any medical services, the Lawyers knew their client—either through third-party-liability insurance or the client's own coverage—did not have $1,100,000 in insurance coverage to pay CAROLINA NEUROSURGERY.

44. The Lawyers allowed CAROLINA NEUROSURGERY to perform the surgeries without advising CAROLINA NEUROSURGERY there earlier promises and assurances were false.

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45. As a direct and proximate result of the Lawyers' breach of contract accompanied with their fraudulent intent, CAROLINA NEUROSURGERY has been injured and suffered damages.

46. WHEREFORE, CAROLINA NEUROSURGERY is entitled to a judgment against the Lawyers for actual damages under the LOP, and for an award of punitive damages and such other and further relief the Court deems just and proper.

FOR A THIRD CAUSE OF ACTION
(Violation of The South Carolina Unfair Trade Practices Act)

47. The foregoing factual and jurisdictional allegations are reiterated and realleged as though set forth verbatim.

48. This is a cause of action under the South Carolina Unfair Trade Practice Act, S.C. CODE ANN. §39-5-10, et seq.

49. The Lawyers engaged in trade or commerce in South Carolina, including practicing law in representing the Lawyers' Client, who, as alleged throughout this Complaint, have engaged in unfair or deceptive acts or practices of trade or commerce. Further, the Lawyers' use of such unfair and/or deceptive acts was willful.

50. The Lawyers' conduct is capable of repetition.

51. As a direct and proximate result of the Lawyers' use or employment of unfair and/or deceptive acts of trade or commerce as described in this Complaint, CAROLINA NEUROSURGERY has suffered an ascertainable loss of money or property.

WHEREFORE, CAROLINA NEUROSURGERY is entitled to and requests an award of actual damages equal to the losses suffered under the LOP, including payment for the medical/surgical services provided to the Lawyers' client, in an amount to be determined by the trier of fact. Further CAROLINA NEUROSURGERY is entitled to and requests an award

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of treble damages, legal fees, and costs, for the Lawyers' willful conduct and statutory violation.

FOR A FOURTH CAUSE OF ACTION
(Fraud)

46. CAROLINA NEUROSURGERY realleges and incorporates the foregoing factual and jurisdictional statements by reference as if they were set forth herein.

47. The Lawyers made representations of fact to CAROLINA NEUROSURGERY concerning the amount of insurance coverage available to pay for medical/surgical services CAROLINA NEUROSURGERY planned to provide to the Lawyers' client.

48. The Lawyers made representations of fact to CAROLINA NEUROSURGERY in the LOP concerning the Lawyer's intent to pay CAROLINA NEUROSURGERY from any recovery the Lawyers obtained on behalf of the Lawyers' client.

49. The representations of fact made by the Lawyers to CAROLINA NEUROSURGERY concerning the amount of insurance coverage available to pay for medical/surgical services CAROLINA NEUROSURGERY planned to provide for the Lawyers' client were false.

50. The representations of fact made by the Lawyers to CAROLINA NEUROSURGERY in the LOP concerning the Lawyer's intent to pay CAROLINA NEUROSURGERY from any recovery the Lawyers obtained on behalf of the Lawyers' client were false.

51. The representations of fact made by the Lawyers to CAROLINA NEUROSURGERY concerning the amount of insurance coverage available to pay for surgical services CAROLINA NEUROSURGERY planned to provide for the Lawyers' client were material to CAROLINA NEUROSURGERY's decision to provide the recommended

surgical services.

52. The representations of fact made by the Lawyers to CAROLINA NEUROSURGERY in the LOP concerning the Lawyer's intent to pay CAROLINA NEUROSURGERY from any recovery the Lawyers obtained on behalf of the Lawyers' client were material to CAROLINA NEUROSURGERY's decision to move forward with the recommended surgical services.

53. The Lawyers either knew the representations they made to CAROLINA NEUROSURGERY were false or the Lawyers made the representations with a reckless disregard of the truth or falsity of those representations.

54. The Lawyers intended for CAROLINA NEUROSURGERY to rely and act upon their representations.

55. CAROLINA NEUROSURGERY was not aware the representations made by the Lawyers were false.

56. CAROLINA NEUROSURGERY relied upon the Lawyers' statements and representations being true.

57. CAROLINA NEUROSURGERY had a right to rely upon the Lawyers' representations.

58. As a direct and proximate result of the Lawyers' false statements and representations, CAROLINA NEUROSURGERY suffered actual, special, and consequential damages in an amount to be proven at trial.

59. Based on the Lawyers' false and fraudulent statements, CAROLINA NEUROSURGERY is entitled to an award of punitive damages in an amount sufficient to deter such similar conduct in the future, in multiple amount exceeding three (3) times the amount of actual damages award.

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60. WHEREFORE, CAROLINA NEUROSURGERY is entitled to and requests an award of actual damages equal to the losses suffered under the LOP, including payment for the medical/surgical services provided to the Lawyers' client, in an amount to be determined by the trier of fact. Further CAROLINA NEUROSURGERY is entitled to and requests an award of punitive damages, legal fees, and costs

FOR A FIFTH CAUSE OF ACTION
(Constructive Fraud)

61. CAROLINA NEUROSURGERY realleges and incorporates the foregoing factual and jurisdictional statements by reference as if they were set forth herein.

62. The Lawyers had duties to CAROLINA NEUROSURGERY to fully and truthfully inform and explain to Dr. Highsmith all matters related to the medical/surgical treatments Dr. Highsmith provided to the Lawyers' clients.

63. The Lawyers knew or should have known that CAROLINA NEUROSURGERY was relying on the special confidence imposed upon the Lawyers based on their duties of candor and truthfulness in statements to others.

64. The Lawyers were, in equity and good conscience, bound to act in good faith and with due regard to D CAROLINA NEUROSURGERY's interests.

65. The Lawyers chose not to fully and truthfully inform and explain to Dr. Highsmith all matters related to the insurance coverage available to cover medical/surgical treatments CAROLINA NEUROSURGERY provided to the Lawyers' client to the extent reasonably necessary for CAROLINA NEUROSURGERY to make informed decisions.

66. The Lawyers' false statements and omissions fraudulently and materially misled CAROLINA NEUROSURGERY.

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67. CAROLINA NEUROSURGERY had no reason to know the falsity of the Lawyers' omissions and false statements.

68. CAROLINA NEUROSURGERY justifiably and in good faith relied upon the Lawyers' omissions and false statements to his pecuniary detriment.

69. CAROLINA NEUROSURGERY suffered and will continue to suffer pecuniary damages as an actual and proximate result of the Lawyers' material omissions and false statements.

70. Based upon the Lawyers' acts and omissions constituting and effecting a constructive fraud, CAROLINA NEUROSURGERY is entitled to an award of punitive damages in an amount determined by the jury.

71. WHEREFORE, CAROLINA NEUROSURGERY prays for judgment on this cause of action against the Lawyers for actual, consequential, and incidental damages suffered; and such other relief as the Court may deem reasonable and proper.

FOR A SIXTH CAUSE OF ACTION
(Unjust Enrichment)

72. CAROLINA NEUROSURGERY realleges and incorporates the foregoing factual and jurisdictional statements by reference as if they were set forth herein.

73. As an alternative cause of action to the Claim of breach of contract, CAROLINA NEUROSURGERY has conferred a benefit upon the Lawyers, including providing surgical services to the Lawyers' client under the LOP.

74. Allowing the Lawyers to retain the value of the benefit of providing surgical services to the Lawyers' client thereby enhancing the settlement value of the Lawyers' client's claim is inequitable without the Lawyers having performed as specified within the LOP.

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75. WHEREFORE, Dr. Highsmith prays the court, sitting in equity, impose upon the Lawyers an obligation to compensate CAROLINA NEUROSURGERY in full for the value of the services Dr. Highsmith provided to the Lawyers' client.

FOR A SEVENTH CAUSE OF ACTION
(Negligence)

76. CAROLINA NEUROSURGERY realleges and incorporates the foregoing factual and jurisdictional statements by reference as if they were set forth herein.

77. The Lawyers had a duty to investigate and ascertain the amount of insurance coverage available to the Lawyers' client before making assurances and representations to CAROLINA NEUROSURGERY about the amount of insurance coverage available.

78. The Lawyers breached their duty to investigate and ascertain the amount of insurance coverage available to the Lawyers' client before making assurances and representations to CAROLINA NEUROSURGERY about the amount of insurance coverage available.

79. As a direct and proximate result of the Lawyers' breach of their duties to investigate the amount of insurance coverage available, CAROLINA NEUROSURGERY incurred actual and consequential damages.

80. WHEREFORE, CAROLINA NEUROSURGERY prays for judgment against the Lawyers for actual, special, and consequential damages, for the costs of this action, and for such other and further relief as this Court deems just and proper.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., prays for judgment against Defendants, Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP,

jointly and severally, for the relief sought in each of the Causes of Action asserted in this Verified Complaint, and for such other and further relief as this Court deems just and proper.

Respectfully submitted,

PENDARVIS LAW OFFICES, P.C.

/s/ Thomas A. Pendarvis
Thomas A. Pendarvis (SC Bar #64918)
Christopher W. Lempesis, Jr. (SC Bar #77012)
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Counsel for Plaintiff

Beaufort, South Carolina

July 22, 2021

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CIVIL ACTION NO.: 2021-CP-10-_____
Carolina Neurosurgery & Orthopedics, Inc.,	)	
Plaintiff,	)	
v.	)	**VERIFICATION**
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
Defendants.	)	

PERSONALLY appeared before me, Jason M. Highsmith. M.D., who, first being duly sworn, says that he has read the foregoing Verified Complaint, that the statements contained therein are true to the best of his knowledge except as to those stated to be based upon information and belief, as to which he believes such matters to be true.

Jason M. Highsmith. M.D.

Sworn to before me this

19th day of July, 2021

Kiara S. Goodwine

NOTARY PUBLIC FOR SOUTH CAROLINA

My commission expires: 8/12/2029

KIARA S. GOODWINE
NOTARY PUBLIC, STATE OF SOUTH CAROLINA
My Commission Expires 8/12/2029

ELECTRONICALLY FILED - 2021 Jul 22 2:24 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

DELUCA MAUCHER

LAW OFFICES

EXHIBIT 1

MICHAEL A. MAUCHER
MIKE@DELUCAMAUCHER.COM
(O) (843) 572-1711 • (F) (843) 572-1285
REPLY TO GOOSE CREEK OFFICE

ELECTRONICALLY FILED - 2021 Jul 22 2:24 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

December 20, 2018

FAX MAIL
(843) 553-1008

Jason H. Highsmith, M.D.
9313 Medical Plaza Drive, Suite 303
Charleston, South Carolina 29406

RE: My Client: Scott DeMaskey
Date of Accident: 12/14/18

Dear Sir or Madam:

With regard to the above-named individual, please accept this correspondence as our Law Firm's agreement to protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding account balance.

With kindest regards, I am,

Very truly yours,

Michael A. Maucher

MAM/tgb
NOTE: To ensure that this office is aware of your medical lien, please provide an itemized billing statement for services rendered.

Fax: (843) 474-0712

Fax: (843) 474-0712

EXHIBIT 2

ELECTRONICALLY FILED - 2021 Jul 22 2:24 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

FINANCIAL POLICY

- **BASIC POLICY:** The patient is responsible for medical bills in our office. Our staff will help with completion of insurance forms as an accommodation and convenience to you without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us, and to negotiate with your insurance company over any disputed claims.
- **IF YOU DO NOT HAVE INSURANCE:** Our policy requires payment in full today, unless other arrangements are made. If you cannot pay in full now, we request partial payment today as you arranged for credit on your account with a payment plan agreement with our credit and collection manager.
- **IF YOU HAVE INSURANCE:** Fill out the insurance section of our form, Carolina Neurosurgery & Orthopedics, Inc. does not accept Medicare, Medicaid or any HMO plan. If you are covered by private insurance or PPO with out of network benefits, please present your identification card to the receptionist at the time of your appointment. I understand, as a courtesy, Carolina Neurosurgery & Orthopedics, Inc. will file with my primary insurance. If after 90 (ninety) days from the date of service from the date of service and/or surgery insurance has not paid, the total balance will be considered due and payable. The Medical Providers are out of network and you may be responsible all or part of your balance.
- **WORKMAN'S COMPENSATION:** In the event it is determined by the worker's compensation board that the illness or injury is not a result of a compensable worker's compensation case, I hereby agree to pay the usual and customer fees for the services rendered.
- **REJECTED CLAIMS:** If your insurance company rejects your claim, or if they pay less than the total bill, our policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay your balance in full after your insurance payment, please call Carolina Neurosurgery & Orthopedics, Inc. and make arrangements to pay your bill.
- **FORMS OF PAYMENT:** We accept payments in cash, check, or money order. Checks must be made payable to Carolina Neurosurgery & Orthopedics, Inc.
- **RETURNED CHECKS:** A $100.00 handling charge is applied to all returned checks.
- **DELINQUENT ACCOUNTS:** Delinquent accounts over 90 days are turned over to our collection manager, unless other arrangements are made. If the bill remains unpaid and satisfactory arrangements for payment are not made, the collection manager will review the account with the doctor to decide appropriate legal action including placing a lien on a third-party case. We reserve the right to addition late charges to delinquent accounts requiring collections action and to addition attorney fees, court costs, and/or collections agency fees. If your account is placed with a 3rd party, they have the right to contact you at any number provided to our office.
- **MONTHLY STATEMENTS:** Once your insurance has paid you are responsible for the unpaid balance. You will receive an itemized monthly statement of any patient balance until your bill is paid in full. Interest of 1.5% (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of $0.50 per month.

If this account is assigned to an attorney for collections and/or suit, Carolina Neurosurgery & Orthopedics, Inc. will be entitled to all attorney's fees and costs of collection.

I hereby authorize payment to healthcare provider for all funds owing to me from my case by way of insurance payments, judgment, verdict or other source which may be paid to my attorney or myself.

In addition to my foregoing, in order to secure my obligation to pay the amount of my charges to healthcare provider, and in consideration for healthcare provider's agreements set forth herein, I hereby grant to healthcare provider, in accordance with the uniform commercial code as in effect in the applicable jurisdiction, a security interest in and lien upon: (I) the proceeds; and (II) all proceeds thereof, in each aseptic whether now owned or hereafter existing, acquired or arising, and wherever located. I authorize healthcare provider to file one or more UCC Financing statements (and continuations thereof) naming me as debtor and evidencing healthcare provider's security interest in such collateral. I hereby authorize my attorney to pay healthcare provider from any proceeds of any settlement, if applicable.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure my records to any third party.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and other health plan.

This assignment may not be revoked by me or anyone else. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I have read and agree to the financial policy of this office.

Scott D

Patient Signature

Appointment Date: 1-3-2019

Send payment to:
Carolina Neurosurgery and Orthopedics Inc.
2910 Tricom Street, Suite 201
N. Charleston
SC, 29406
Phone No : 843-510-0727 Fax : 843-474-0712

Page	Account#	Statement Date
page 1 of 1	177271	11/02/2020

EXHIBIT 3

TOTAL BALANCE: $125,409.28
(PLEASE PAY THIS AMOUNT)

Bill to:
SCOTT DEMASKEY
112 MCLAURIN AVE
SUMMERVILLE,SC
29483

Patient: SCOTT DEMASKEY (177271)

Date	Description	Charges	Payment	Balance
	You are responsible for the following charges:			
12/20/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
09/06/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
07/18/19	POST OP	0.00	0.00	0.00
07/18/19	XRAY REVIEW	180.00	0.00	180.00
06/13/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
05/24/19	POST OP	0.00	0.00	0.00
05/02/19	Bilateral L4-S1 Posterior Decompression with L4 Microdiscectomy, Bilateral / Intraoperative Fluoroscopy with Interpretation / Intraoperative Microscope Use	62,451.87	0.00	62,451.87
04/26/19	POST OP	0.00	0.00	0.00
04/04/19	POST OP	0.00	0.00	0.00
03/15/19	C6-7 Anterior Cervical Discectomy & Fusion, C6-7 / Interbody Cage x1 / Anterior Instrumentation / Global Instrumentation / Intraoperative Fluoroscopy with Interpretation / Intraoperative Micr	58,697.41	0.00	58,697.41
03/07/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
01/21/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
01/21/19	XRAY REVIEW	180.00	0.00	180.00
01/21/19	MRI OF CERVICAL W/O CONTRAST	300.00	0.00	300.00
01/21/19	MRI OF LUMBAR W/O CONTRAST	300.00	0.00	300.00
01/02/19	NP MOD.HIGH COMPLEX	900.00	0.00	900.00
	TOTAL BALANCE ----->			$125,409.28

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EXHIBIT 4

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Tina

From: Kiara Goodwine <kiara@orthoandneuro.com>
Sent: Monday, January 21, 2019 12:11 PM
To: Tina
Cc: 'Scott DeMaskey'
Subject: Re: Scott DeMaskey

Okay thanks for the update !

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Tina <Tina@delucamaucher.com>
Sent: Monday, January 21, 2019 11:58:35 AM
To: Kiara Goodwine
Cc: 'Scott DeMaskey'
Subject: Scott DeMaskey

Kiara,

Scott DeMaskey has advised our office that he will require surgery. Based upon the serious nature of his injury, and his pre-existing injuries, we would respectfully request that all of his treatment be filed with his private health insurance company. It would be best for everyone involved if we NOT do the treatment under an Assignment/Letter of Protection.

On a separate matter, please provide this office with the office note and/or documentation which shows the recommended surgery.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

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Tina

From: Tina
Sent: Monday, January 21, 2019 9:24 AM
To: 'Kiara Goodwine'
Cc: Brooke Dunsil; Kary Garcia
Subject: RE: Scott Demaskey

Kiara,

The at-fault party had a North Carolina Policy of automobile insurance. In order for them to disclosure the limits of their North Carolina Policy, we must provide them with a signed Medical Authorization allowing them to obtain copies of Scott Demaskey's medical records. We are NOT willing to comply with that request. We are therefore unable to find out how much Liability Coverage is on their policy. Because Mr. Demaskey carries $100,000.00 in UnderInsured Motorist Coverage on his at-home policy with Safeco, and there is $1,000,000.00 in "Occupational Accident Coverage" to pay bills and wages under the One Beacon Policy, we are not concerned that there will be enough over all coverage to pay the claim.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

From: Kiara Goodwine [mailto:kiara@orthoandneuro.com]
Sent: Wednesday, January 16, 2019 4:12 PM
To: Tina
Cc: Brooke Dunsil; Kary Garcia
Subject: Scott Demaskey

Good afternoon,

May I please get limits on patient Scott Demaskey DOB Reda /54

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

Tina

From: Kiara Goodwine <kiara@orthoandneuro.com>
Sent: Monday, January 21, 2019 12:11 PM
To: Tina
Cc: 'Scott DeMaskey'
Subject: Re: Scott DeMaskey

EXHIBIT 5

Okay thanks for the update !

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Tina <Tina@delucamaucher.com>
Sent: Monday, January 21, 2019 11:58:35 AM
To: Kiara Goodwine
Cc: 'Scott DeMaskey'
Subject: Scott DeMaskey

Kiara,

Scott DeMaskey has advised our office that he will require surgery. Based upon the serious nature of his injury, and his pre-existing injuries, we would respectfully request that all of his treatment be filed with his private health insurance company. It would be best for everyone involved if we NOT do the treatment under an Assignment/Letter of Protection.

On a separate matter, please provide this office with the office note and/or documentation which shows the recommended surgery.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
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Goose Creek, SC 29445
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EXHIBIT 6

Subject: **Fw: Scott Demaskey**
Date: 1/3/2020 2:21:54 PM Eastern Standard Time
From: kiara@orthoandneuro.com
To: edweinberger@aol.com

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Tina <Tina@delucamaucher.com>
Sent: Thursday, March 7, 2019 9:34 AM
To: Kiara Goodwine <kiara@orthoandneuro.com>
Subject: Scott Demaskey

Please see attached LOP. This LOP covers whatever is NOT paid by private health insurance.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

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DeLUCA MAUCHER
LAW OFFICES

MICHAEL A. MAUCHER
MIKE@DELUCAMAUCHER.COM
(O) (843) 572-1711 • (F) (843) 572-1285
REPLY TO GOOSE CREEK OFFICE

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March 7, 2019

Jason H. Highsmith, M.D.
9313 Medical Plaza Drive, Suite 305
Charleston, South Carolina 29406

RE: My Client: Scott Demaskey
Date of Accident: 12/14/18

Dear Sir or Madam:

With regard to the above-named individual, please accept this correspondence as our Law Firm's agreement to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding account balance.

With kindest regards, I am,

Very truly yours,

Michael A. Maucher

MAM/tgb
NOTE: To ensure that this office is aware of your medical lien, please provide an itemized billing statement for services rendered.

Subject: **Fw: Scott Demaskey**
Date: 1/3/2020 2:22:38 PM Eastern Standard Time
From: kiara@orthoandneuro.com
To: edweinberger@aol.com

EXHIBIT 7

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Kiara Goodwine
Sent: Tuesday, March 19, 2019 5:44 PM
To: Tina <tina@delucamaucher.com>
Cc: Kary Garcia <Kary@orthoandneuro.com>
Subject: Scott Demaskey

Good afternoon,

Attached is OP report from 3/15

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

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Center for Advanced Surgery
3821 Commercial Center Drive
Ladson, South Carolina 29456
843.628.0510 phone
CenterforAdvancedSurgery.com

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OPERATIVE REPORT

PATIENT NAME: DEMASKEY, SCOTT
MEDICAL NUMBER: Red
DATE OF BIRTH: Reda /1954
SURGEON: JASON M. HIGHSMITH, MD
DATE OF OPERATION: 03/15/2019

PREOPERATIVE DIAGNOSIS: Cervical disc disruption at C6-7 with bilateral C7 radiculopathy.

POSTOPERATIVE DIAGNOSIS: Cervical disc disruption at C6-7 with bilateral C7 radiculopathy.

OPERATIONS PERFORMED:
1. Anterior cervical discectomy and fusion, C6-7.
2. Interbody cage x1.
3. Anterior instrumentation.
4. Intraoperative fluoroscopy with interpretation.
5. Intraoperative microscope use.

SURGEON: Jason M. Highsmith, MD

ASSISTANTS: None.

INDICATIONS FOR SURGERY: The patient is a gentleman with a history of worsening neck and radicular arm pain and neurologic impingement at C6-7. He is felt to be a candidate for anterior cervical discectomy and fusion having failed less invasive measures. He understands the risks, benefits, and alternatives of procedure. Specific risks discussed included but not limited to bleeding, infection, neurologic injuries, spinal fluid leakage, subsidence, hoarseness, swallowing difficulty, loss of motion, risk of adjacent segment disease, and worsening or no improvement in symptoms.

DESCRIPTION OF PROCEDURE: After obtaining informed consent, the patient was taken to the operating room where he underwent the successful induction of general endotracheal anesthesia. The neck was mildly extended and prepped and draped in standard sterile fashion. A #10 blade scalpel was used to open a healed incision from the C5-6 fusion. We carried out dissection medial to the sternocleidomastoid and carotid sheath down to the prevertebral fascia and localized at C6-7. Caspar pin was placed at C7 body and in the interbody graft at C5-6. Distraction was carried out. We carried out anterior discectomy from significant broad-based disruption posteriorly with neurologic impingement and lateral foramen stenosis. This was carefully debrided and resected in addition to the posterior longitudinal ligament to provide a generous decompression of the cord and exiting nerve roots. We noted erythema on the right C7 exiting nerve root. We explored the epidural space and found it to be free of injury. We copiously irrigated the wound with bacitracin solution and sized extra and extra large 5 mm Globus coalition implant in the interspace which we anchored in place with cranially and caudally directed screws and filled with allograft. AP and lateral fluoroscopy showed adequate placement of the hardware. We engaged the locking mechanism. We inspected the soft tissues and found them to be free of injury. We then closed the wound in anatomic layers followed by application of sterile dressing. . All sponge and needle counts were correct at the end of the case.

ESTIMATED BLOOD LOSS: 150 mL from venous plexus.

OPERATIVE COMPLICATIONS: None apparent.

Jason M. Highsmith, MD

JH/TS/iMD/Job# 4435

DD: 03/15/2019
DT: 03/15/2019

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EXHIBIT 8

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Carolina Neurosurgery & Orthopedics, Inc.

9313 Medical Plaza, Suite 303
North Charleston, South Carolina 29406
Charleston Office: (843) 510-0727
Fax: (843) 474-0712

161 Medical Cir
West Columbia, South Carolina 29169
Columbia Office (803) 764-1813
Fax: (843) 474-0712

Health Insurance Verification Form For Surgery

MRN #:_____

Patient Name: Scott DeMarks

DOB: Redacted 1/54 SSN: Redacted

Insurance Company:_____

ID #:_____

Group#:_____

Please Provide a copy of your insurance card

☑ I do not have Health Insurance at this time

Scott DeMarks
Patient Name

4/26/19
Date

Scott DeMarks
Patient Signature

Kiara G.
Witness

4/26/19
Date

EXHIBIT
9

ELECTRONICALLY FILED - 2021 Jul 22 2:24 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Tina

From: Tina
Sent: Monday, April 29, 2019 12:31 PM
To: 'Melinda Roten'
Cc: 'Scott DeMaskey'
Subject: RE: S. Demaskey

Yes, please move forward with BCBS. Unfortunately, Mr. DeMaskey will need to be responsible for his co-pay.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

From: Melinda Roten [mailto:mroten@chscas.com]
Sent: Monday, April 29, 2019 12:14 PM
To: Tina
Cc: 'Scott DeMaskey'
Subject: RE: S. Demaskey

Okay we have BCBS on file. We can file through insurance. However since the letter of protection is being taken away he would be responsible for his 500 co payment associated with his insurance. Please let me know how you would like me to proceed

---

From: Tina <Tina@delucamaucher.com>
Sent: Monday, April 29, 2019 11:29 AM
To: Melinda Roten <mroten@chscas.com>
Cc: 'Scott DeMaskey' <dem6060@gmail.com>
Subject: RE: S. Demaskey

Melinda,

Because the at-fault party only had $30,000.00, and Scott DeMaskey's Underinsured Motorist Coverage does not apply, all treatment will need to proceed under his private health insurance. We cannot honor anymore treatment under a Letter of Protection. Please note Mr. DeMaskey's file accordingly.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher

Subject: **Fw: Scott Demaskey**
Date: 1/3/2020 2:23:13 PM Eastern Standard Time
From: kiara@orthoandneuro.com
To: edweinberger@aol.com

EXHIBIT 10

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Kiara Goodwine
Sent: Tuesday, April 30, 2019 7:44 AM
To: Tina <tina@delucamaucher.com>
Cc: Kary Garcia <Kary@orthoandneuro.com>
Subject: Scott Demaskey

Good morning,

Attached are notes and bill ledger from previous visit.

NEXT APPT: 05/02/2019

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

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Carolina Neurosurgery & Orthopedics, Inc.

9313 Medical Plaza, Suite 303
North Charleston, South Carolina 29406
Charleston Office: (843) 510-0727
Fax: (843) 474-0712

161 Medical Cir
West Columbia, South Carolina 29169
Columbia Office (803) 764-1813
Fax: (843) 474-0712

Dear: SCOTT PYMASKEY

You have been scheduled for your procedure on 5/21/19.

It is scheduled at the following location:

X Center For Advanced Surgery 3821 Commercial Center Drive Ladson, Sc 29456 Phone: 843-628-5695	Surgeon: X Jason Highsmith, M.D.

You are scheduled for a B LUMBAR DECOMP L4-S1

Please initial below that you have read and understand the following:

SP **DO NOT** take aspirin, Advil, Motrin or anything that contains aspirin or is a blood thinner seven (7) days prior to surgery.

SP **DO NOT** have anything to eat or drink after midnight the night before surgery. This includes chewing gum or eating mints. **NO ALCOHOL 48 HOURS PRIOR TO SURGERY.**

SP **YOU MUST BRING YOUR MRI** films, back brace or collar (if applicable) with you the day of surgery.

SP **YOU MUST** have someone drive you to and from the surgery AND you must have someone at home to take care of you after the procedure.

Scott D. Pymasky
Patient Signature

4/26/19
Date

Post-Op Appt: 5/24/19 @ 8:30am

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ELECTRONICALLY FILED - 2021 Jul 22 2:24 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Carolina Neurosurgery & Orthopedics, Inc.

9313 Medical Plaza, Suite 303
North Charleston, South Carolina 29406
Charleston Office: (843) 510-0727
Fax: (843) 474-0712

161 Medical Cir
West Columbia, South Carolina 29169
Columbia Office (803) 764-1813
Fax: (843) 474-0712

Health Insurance Verification Form For Surgery

MRN #:_____

Patient Name: Scott D Marks

DOB: Redacted 54 SSN: Redacted

Insurance Company:_____

ID #:_____

Group#:_____

Please Provide a copy of your insurance card

☑ I do not have Health Insurance at this time

Scott D Marks
Patient Name

4/26/19
Date

Scott D Marks
Patient Signature

Kiara G.
Witness

4/26/19
Date

Carolina Neurosurgery & Orthopedics, Inc.

9313 Medical Plaza, Suite 303
North Charleston, South Carolina 29406
Charleston Office: (843) 510-0727
Fax: (843) 474-0712

161 Medical Clr
West Columbia, South Carolina 29169
Columbia Office (803) 764-1813
Fax: (843) 474-0712

Patient Name: SCOTT DYMASKEY

1) I authorize the following procedure (s):

2) The procedure will be performed by a physician at Carolina Neurosurgery & Orthopedics, Inc.. or surgical assistants, banked tissue, tissue substitutes equipment, devices, products or instruments, etc as needed. SD pt

3) I consent to the performance of procedures and treatments in addition to or different from that named above if during the course of the procedure, the physician considers such additions or changes necessary, appropriate or advisable. I authorize Carolina Neurosurgery & Orthopedics, Inc. to tender care and services that are customary and necessary with respect of all such procedures and treatments. SD pt

4) I have conferred with the said physicians and/or other physicians about the nature of the procedures, the possibility that complications may arise or develop, risks, which may be involved, and possible alternate methods of treatment. SD pt

5) I understand that no warranty or guarantee has been made as to the results or treatment. SD pt

6) I authorize and direct the above named physician and/or his associates and assistants to provide such additional service as they deem reasonable and necessary including, but limited to the administration and maintenance of anesthesia, the administration of blood and blood procedures, the administration of intrathecal narcotics, and the performance of ancillary services (Pathology, X-rays, Radiology, etc.). SD pt

7) I give permission that any tissues, parts or devices surgically removed may be retained or disposed of Carolina Neurosurgery & Orthopedics, Inc. in accordance with its accustomed practice. SD pt

8) I understand that some devices available for use in spinal procedures may be developmental, investigational and/or not yet approved by U.S. Governmental agencies. SD pt

9) I give permission to document all or a portion of my procedure by photographs, videotapes or other means and consent to release of such materials in the presentations, publications, etc. In addition, the procedure may be observed for educational purposes. SD pt

10) I understand that certain behaviors, actions and/or habitus may adversely the affect the outcome of my procedure. Examples of such actions, behaviors, and/or habitus are tobacco use, alcohol use, recreational drug use, noncompliance with physician recommendations, etc. SD pt

11) I understand that since prescription narcotic drugs can be addictive and habit forming, it is the policy of this office that these medications will only be prescribed for two (2) weeks following surgery. SD pt

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12) I realize that, as with any form of treatment, whether surgical or non-surgical, complications may arise. Complications can occur during any hospitalization related to general medical conditions, anesthesia or surgery. Certain complications are specific for each type of Procedure. I also realize that no matter how extensive, exhaustive and complete is the list of potential complications, other unforeseen or unexpected complications or events may occur. These types of complications related to my procedure and hospitalization, both general and specific, have been discussed with me. I understand and agree to proceed with surgery. GL pt

13) I have received an explanation of this procedure as stated above and give my informed consent to it performance. I hereby release Carolina Neurosurgery & Orthopedics, Inc. from any further responsibility for obtaining additional permission to perform this procedure. GL pt

14) This Healthcare Provider does not provide samples of medication. I understand that I must have my prescriptions filled at a pharmacy. GL pt

Patient: Scott P

Date: 4/26/19

Witness: Kiara G.

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Carolina Neurosurgery & Orthopedics, Inc.

9313 Medical Plaza, Suite 303
North Charleston, South Carolina 29406
Charleston Office: (843) 510-0727
Fax: (843) 474-0712

161 Medical Cir
West Columbia, South Carolina 29169
Columbia Office (803) 764-1813
Fax: (843) 474-0712

Cost of Surgery Form

Date: 4/26/19

Name: Scott R. Mack

SSN: Redacted

DOB: Redacted 54

Account #:

You have been scheduled for a: B Lumbar Dfcamp. L4-S1

The approximate cost of the procedure is: $65,000.00

I fully understand that this is an estimate. The above listed fee is subject to change. This price only includes the physician's surgical charges. The hospital/surgery center and anesthesiologist bill separately for services performed and are NOT included in the price listed above.

I fully understand the information listed above and all of my questions have been answered.

Patient Signature: Scott

OFFICE USE ONLY

Witness: Kiara G.

Date: 4/26/19

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West Columbia, South Carolina 29169
Columbia Office (803) 764-1813
Fax: (843) 474-0712

NOTICE TO OUR SURGICAL PATIENTS

Patient Name: Scott DeMaskey Date: 4/26/19

Your surgery has been scheduled for 5/2/19

at CAS

Scheduling surgery/injections is a lengthy process, involving time and cost to the surgeon's office, as well as the surgical facility. During this surgery, the physicians and/or staff may take photographs of you during this procedure.

If a surgery is cancelled at the last moment these costs multiply significantly. Additionally, other patients who are waiting for surgery cannot be scheduled as we have blocked out time for your surgery. The facility cannot accommodate their numerous other patients as well as they too have scheduled time for your procedure.

Due to these factors we find it necessary to charge for cancelled surgeries. We must receive notice of the cancellation at least two (2) weeks prior to the scheduled surgical date. The following charge will apply to any and all surgeries that are cancelled without adequate notice.

For patients scheduling surgery: If we are not given at least two (2) weeks notice you will be charged a standard surgical cancellation fee of $10,000.

For patients scheduling injections: If we are not given at least one (1) week notice you will be charged a standard surgical cancellation fee of $3,000.

Occasionally, surgeries may be cancelled at the last moment due to medical reasons that may not be under your control. In this case the cancellation fee may be waived at the surgeon's discretion.

Please be sure that you want to go ahead with the surgery on the date that we have scheduled you for. If any problems, changes or emergencies arise please notify the office at once.

We require notification of the intent to cancel this surgery by 4/26/19 in order for you to avoid the cancellation fee.

Signature: Scott DeMy Date: 4/26/19

Witness: Kiara Goodwine Date: 4/26/19

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Carolina Neurosurgery & Orthopedics, Inc.

161 Medical Circle
West Columbia, SC 29169
Phone: (803) 764-1813
Fax: (843) 474-0712

2910 Tricom Street, Suite 201
North Charleston, SC 29406
Phone: (843) 510-0727
Fax: (843) 474-0712

POSTOPERATIVE VISIT

Patient Name: Scott Demaskey
Record #: 177271
Date: 04/26/2019
Date of Birth: Redac/1954
Date of Injury: 12/14/2018

Subjective: The patient returns today having undergone anterior cervical discectomy and fusion at C6-7 on 03/15/2019. He reports improvement in his radicular neck and arm pain. He still has some posterior neck stiffness and discomfort but he is concerned primarily about his lower extremity numbness and paresthesias. He has difficulty walking for prolonged time without significant pain and discomfort. His pain is improved with forward flexion with history of tingling in the feet bilaterally. He is here today to discuss additional treatment options.

Review of Systems:
General: Negative for dizziness, chills, fevers or sweats.
Musculoskeletal: Significant as in HPI.
Genitourinary: Denies blood in urine, frequent urination, or lack of bowel or bladder control. Denies any sexual dysfunction.
Skin: Denies bruising easily, itching or rashes.
Gastrointestinal: Denies nausea, vomiting or indigestion.
Cardiovascular: Denies chest pain.
HEENT: Denies blurry vision, bleeding gums, double vision, earaches or hoarseness.

Medications: Atorvastatin, valsartan, hydrochlorothiazide, Flomax, diclofenac, Tylenol and Motrin.

Allergies: Latex and Vicodin.

Physical Examination: General: The patient is a well-nourished and well-developed male who presents today for evaluation. Vital Signs: Stable. Afebrile. Height is 5 feet 9 inches and weight is 227 pounds. HEENT: Head is normocephalic. Neck: Supple. Chest: Nontender. Cardiovascular: Regular. Abdomen: Nontender. Neurological: Cranial nerves II through XII are grossly intact. Musculoskeletal: Strength is 5/5 throughout. Deep tendon reflexes are 2/4 throughout. Negative Hoffmann. Negative clonus. Negative Babinski sign.

Sensation diminished in the calves bilaterally; otherwise intact to pinprick and light touch throughout. Physical exam of the cervical spine reveals a well-healing incision. The patient has mild tenderness to palpation of the cervical paraspinous muscle with palpable muscle spasm present. Trigger points are identified in the right and left splenius capitis, trapezius and rhomboids. The patient is minimally tender at the midline from occiput to C7 with improved range of motion and minimal pain at the endpoints. Negative Spurling maneuver and negative Lhermitte sign.

Physical exam of the lumbar spine reveals moderate-to-severe tenderness to palpation of the lumbar paraspinous muscles with palpable muscle spasms present. Trigger points are identified in the right and left quadratus lumborum. The patient is moderately tender at the midline from L3 to S1 with limited range of motion and pain at the endpoints. No SI joint tenderness. Negative FABER's test. Negative straight leg raise.

Diagnostic Assessment:

1. Axial neck pain with bilateral upper extremity radiculopathy, right greater than left.
2. Axial low back pain with bilateral lower extremity radiculopathy.
3. Status post C5-6 anterior cervical discectomy and fusion November 2015.
4. Status post cervical laminectomy in California in approximately 2000.
5. Cervical disc disruptions at C2-3, C3-4 and C4-5.
6. Status post C6-7 anterior cervical discectomy and fusion on 03/15/2019.
7. Cervical disc disruption at C7-T1 with moderate neural foraminal narrowing on the left.
8. Lumbar disc disruptions from L2 to S1, most notable at L3 to S1.

Treatment/Recommendations: We discussed most definitive surgical treatment for lumbar spine would include posterior decompression at the L4 to S1 levels. We discussed the risks, benefits, alternatives of the surgery. The patient understands and wishes to proceed.

Jason M. Highsmith, M.D., FACS
Board Certified in Neurological Surgery
JMH/pmt

Dictated but not proofread

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Send payment to:
Carolina Neurosurgery and Orthopedics Inc.
2910 Tricom Street, Suite 201
N. Charleston
SC, 29406
Phone No : 843-510-0727 Fax : 843-474-0712

Page	Account#	Statement Date
page 1 of 1	177271	04/30/2019

Bill to:
SCOTT DEMASKEY
112 MCLAURIN AVE
SUMMERVILLE,SC
29483

TOTAL BALANCE: $61,337.41
(PLEASE PAY THIS AMOUNT)

Patient: SCOTT DEMASKEY (177271)

Date	Description	Charges	Payment	Balance
	You are responsible for the following charges:			
04/26/19	POST OP	0.00	0.00	0.00
04/04/19	POST OP	0.00	0.00	0.00
03/15/19	C6-7 Anterior Cervical Discectomy & Fusion, C6-7 / Interbody Cage x1 / Anterior Instrumentation / Global Instrumentation / Intraoperative Fluoroscopy with Interpretation / Intraoperative Micr	58,697.41	0.00	58,697.41
03/07/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
01/21/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
01/21/19	XRAY REVIEW	180.00	0.00	180.00
01/21/19	MRI OF CERVICAL W/O CONTRAST	300.00	0.00	300.00
01/21/19	MRI OF LUMBAR W/O CONTRAST	300.00	0.00	300.00
01/02/19	NP MOD.HIGH COMPLEX	900.00	0.00	900.00
	**TOTAL BALANCE -----> **			**$61,337.41**

Total Charges	61,337.41
Total Payments	0.00
Total Adjustments	0.00

Balance	61,337.41
Insurance Balance	0.00
Patient Balance	61,337.41

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Subject: **Fw: Scott Demaskey**
Date: 1/3/2020 2:23:39 PM Eastern Standard Time
From: kiara@orthoandneuro.com
To: edweinberger@aol.com

EXHIBIT 11

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Kiara Goodwine
Sent: Monday, May 6, 2019 7:10 AM
To: Tina <tina@delucamaucher.com>
Cc: Kary Garcia <Kary@orthoandneuro.com>
Subject: Scott Demaskey

Good morning,

Attached is OP report from 5/2

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

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Center for Advanced Surgery
3821 Commercial Center Drive
Ladson, South Carolina 29456
843.628.0510 phone
CenterforAdvancedSurgery.com

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OPERATIVE REPORT

PATIENT NAME: DEMASKEY, SCOTT
MEDICAL NUMBER: Redact
DATE OF BIRTH: Redac/1954
SURGEON: JASON M. HIGHSMITH, MD
DATE OF OPERATION: 05/02/2019

PREOPERATIVE DIAGNOSIS: Lumbar disc disruption, L4 to S1.

POSTOPERATIVE DIAGNOSIS: Lumbar disc disruption, L4 to S1.

PROCEDURES PERFORMED:
1. L4-5 and L5-S1 posterior decompression with microdiscectomy bilateral.
2. Intraoperative fluoroscopy with interpretation.
3. Intraoperative microscope use.

SURGEON: Jason M. Highsmith, MD

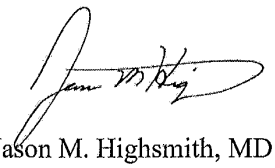
ASSISTANTS: None.

INDICATION FOR PROCEDURE: The patient is a gentleman with history of worsening low back and radicular leg pain bilaterally. He is felt to be a candidate for surgical decompression having failed less invasive measures. He understands the risks, benefits, and alternatives of procedure. Specific risks discussed include, but not limited to bleeding, infection, neurologic injuries, spinal fluid leakage, subsidence, recurrence, reherniation, worsening or no improvement in pain, failure to relieve symptoms, need for revision as well as risks of anesthesia.

PROCEDURE IN DETAIL: After obtaining informed consent, the patient was taken to the operating room where he underwent a successful induction of general endotracheal anesthesia. He was turned prone on the Wilson frame. All pressure points were padded. The back was prepped and draped in standard sterile fashion. A 10-blade scalpel was used to make an incision at the L5 lamina. A subperiosteal dissection was carried out over the spinous process and lamina bilaterally at L4-5 and L5-S1. Decompressive hemilaminotomies were carried out at both levels to expose the lateral recess which was carefully decompressed to provide a generous decompression of the thecal sac and traversing nerve roots. We then decompressed medially as well. We explored the disc at both levels. We found a broad based disc disruption which we debrided to provide additional decompression of the neural elements. We copiously irrigated the wound with bacitracin solution. We inspected the soft tissues and found them to be free of injury. We then closed the wound in anatomic layers followed by application of sterile dressing. All sponge and needle counts were correct at the end of the case.

ESTIMATED BLOOD LOSS: Less than 100 cc.

COMPLICATIONS: None apparent.



Jason M. Highsmith, MD

JH/GK/iMD/Job# 5470

DD: 05/02/2019
DT: 05/02/2019

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ELECTRONICALLY FILED - 2021 Oct 22 4:11 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	IN THE NINTH UDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopaedics, Inc.,	)	
	)	**DEFENDANTS' MOTION TO DISMISS**
Plaintiff,	)	
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	
	)	

TO: THOMAS A. PENDARVIS, ESQ., ATTORNEY FOR PLAINTIFF:

YOU WILL PLEASE TAKE NOTICE, that Defendants Michael A. Maucher, Esq. ("Maucher") and Deluca & Maucher, LLP ("D&M") (collectively, "Defendants"), by and through their undersigned counsel, will move on the tenth day after service hereof, and do hereby move, before this Honorable Court for an Order dismissing Plaintiff's Complaint with prejudice, pursuant to Rule 12(b)(6), SCRCP.

Plaintiff's Complaint fails to state facts sufficient to constitute causes of action against Defendants for Breach of Contract, Fraud, Constructive Fraud, Breach of Contract Accompanied by a Fraudulent Act, Unjust Enrichment, and Negligence for the following reasons:

(1) The Complaint fails to state facts sufficient to constitute a cause of action for Negligence against Defendants because Plaintiff is a non-client, third party to whom Defendants do not owe a duty.

(2) Pursuant to S.C. Code Ann. § 15-36-100(F), this Court should dismiss the Complaint with prejudice because Plaintiff failed to file as part of the Complaint an affidavit of an expert witness.

(3) The Complaint fails to state facts sufficient to constitute a cause of action for Fraud or Constructive Fraud because no confidential or fiduciary relationship exists between Plaintiff and Defendants, and therefore, Plaintiff did not have the right to rely on any

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alleged statements or omissions by Defendants. Further, because Plaintiff had the means to discover the truth as to the state of Defendants' client's insurance coverage, Plaintiff did not have the right to rely on any representations relating thereto by Defendants.

(4) The Complaint fails to state facts sufficient to constitute a cause of action for Unjust Enrichment because it fails to specifically identify any non-gratuitous benefit conferred upon or realized by Defendants.

(5) The Complaint fails to state facts sufficient to constitute a cause of action for Breach of Contract Accompanied by a Fraudulent Act. To the extent the Letters of Protection sent by D&M constitute valid, binding contracts obligating Defendants to pay Plaintiff out of settlement proceeds recovered for Defendants' client, which Defendants' deny, Defendants have not breached the Letters of Protection. Defendants have attempted to tender payment to Plaintiff, but Plaintiff wrongfully refused it.

Additionally, the Complaint fails to allege any fraudulent intent on the part of Defendants specifically relating to the alleged breaching of the Letters of Protection and not merely to their making, and it fails to specifically identify a fraudulent act of Defendants accompanying any alleged breach of the Letters of Protection.

(6) To the extent the Letters of Protection sent by D&M constitute valid, binding contracts obligating Defendants to pay Plaintiff out of settlement proceeds recovered for Defendants' client, Defendants have attempted to tender such payment to Plaintiff, and Plaintiff refused it. Therefore, because Plaintiff's wrongful refusal has impeded Defendants in the performance of their obligation, Defendants are entitled to judgment as a matter of law that they have not breached the Letters of Protection.

WHEREFORE, based on the foregoing, in addition to any other reasons submitted via supplemental Memorandum prior to a hearing on this matter, Defendants respectfully request the Court dismiss Plaintiff's Complaint with prejudice, with all costs of this action, including reasonable attorney's fees, taxed to Plaintiff, and for such other and further relief the Court deems just and proper. With regard to Plaintiff's claims for Breach of Contract, Breach of Contract Accompanied by a Fraudulent Act, and Unjust Enrichment, Defendants further reserve

the right to convert this motion to a motion for summary judgment in the event matters outside the pleadings are presented to the Court for consideration, pursuant to Rule 12(b), SCRCP.

This 22nd day of October, 2021.

Respectfully submitted,

COPELAND, STAIR, KINGMA & LOVELL, LLP

By: *s/Douglas W. MacKelcan*
DOUGLAS W. MACKELCAN
State Bar No.: 76332
MICHAEL C. MASCIALE
State Bar No.: 103819
Attorneys for Defendants

40 Calhoun Street, Suite 400
Charleston, SC 29401-3531
dmackelcan@cskl.law
mmasciale@cskl.law
Ph: 843-727-0307

6674375v.1

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ELECTRONICALLY FILED - 2022 Feb 23 4:59 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, Defendants.	**PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS**

TO: DOUGLAS W MACKELCAN, ESQ. AND MICHAEL C. MASCIALE, ESQ., COUNSEL FOR DEFENDANTS:

Plaintiff respectfully submits this Memorandum in Opposition to the Motion to Dismiss filed on behalf of Defendants, Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP (collectively "the Lawyers"). This Court should deny the Lawyers' Motion based on the allegations in the Verified Complaint, the South Carolina Rules of Civil Procedure, and the common law of South Carolina.

Standard of Review

In reviewing a motion to dismiss, the court must accept as true the well-pleaded facts in the complaint. See Gressette v. S.C. Elec. & Gas Co., 370 S.C. 377, 379, 635 S.E.2d 538, 538 (2006). Since "a judgment on the pleadings is considered to be a drastic measure," a motion to dismiss under Rule 12(b)(6) should not be granted if facts alleged and inferences reasonably deducible therefrom entitle a plaintiff to any relief under any theory of the case. Id.; Overcash v. S.C. Elec. & Gas Co., 364 S.C. 569, 572, 614 S.E.2d 619, 620 (2005). "The ruling on a Rule 12(b)(6), SCRCP motion to dismiss must be based solely upon the allegations set forth in the complaint. … The question to be considered is whether in the light most favorable to the plaintiff, and with every doubt resolved in his behalf, the complaint states any valid claim for relief." Cowart v. Poore, 523 S.E.2d 182, 184-85, 337 S.C. 359, 363-64 (Ct. App.1999) (internal citations omitted). The court should

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deny Defendant's Motion to Dismiss if the "facts alleged in the complaint and inferences reasonably deducible therefrom would entitle plaintiff to any relief on any theory of the case." Brown v. Leverette, 291 S.C. 364, 366, 353 S.E.2d 697 (1987) (internal citations omitted).

"[W]here complaint is dismissed under 12(b)(6), plaintiff should be granted leave to file an amended complaint." Dockside Ass'n v. Detyens, Simmons, et al., 297 S.C. 91, 95, 374 S.E.2d 907, 909 (Ct. App. 1988).

ARGUMENTS IN OPPOSITION

I. The Complaint states facts sufficient to constitute a cause of action for Negligence because it alleges the Lawyers made representations to Plaintiff about the amount of insurance coverage available to induce Plaintiff to perform surgeries to benefit the Lawyers' client and improve the damages aspect of the patient/client's personal injury claim.

There are no legal malpractice / lawyer professional liability claims asserted in this lawsuit. Like anyone else, lawyers can be liable for negligently making false, inaccurate, or misleading representations to parties other than their clients. Stated differently, lawyers can make false, inaccurate, or misleading representations to non-clients to whom they owe no professional duties. See Redwend Ltd. P'ship v. Edwards, 354 S.C. 459, 473, 581 S.E.2d 496, 504 (Ct. App. 2003) ("defendant owed a duty of care to see that he communicated truthful information to the plaintiff"). The Lawyers' motion to dismiss effectively asks this Court to create a special protection for lawyers otherwise unavailable to other individuals and entities. Comprehensive research through existing South Carolina jurisprudence revealed no statutes, regulations, or case law creating a special protection for lawyers or law firms effectively immunizing them from tort liability for false, inaccurate, or misleading representations.

"To sustain an action for negligence, it is essential the plaintiff demonstrate the defendant breached a duty of care owed to the plaintiff." Doe v. Marion, 361 S.C. 463, 471, 605 S.E.2d 556, 560 (Ct. App. 2004). The Verified Complaint is replete with allegations the Lawyers had and breached a duty to Plaintiff concerning the Lawyers' representations to Plaintiff about the availability of insurance coverage to cover medical and surgical expenses for one of the Lawyers' clients, who was also one of Plaintiff's

In re Conway, 374 S.C. 75, 77, 647 S.E.2d 235, 236 (2007) (lawyer disciplined for not paying court reporter for her services)

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patients. See (Verified Complaint, ¶¶ 1, 11-13, 16, 19-25, 29, 31, 37, 41, 39,[1] 40-42, and 47-50). The Verified Complaint states facts sufficient to constitute a cause of action for Negligence.

> Negligence is the want of due care; and due care means commensurate care under all the circumstances. The lack of diligence or want of due care may consist in doing the wrong thing at the time and place in question, or it may arise from inaction when something should have been done. The rule is constant, while the degree of care which a reasonably prudent man exercises, varies with the exigencies of the occasion.

Thomas v. Atlantic Greyhound Corp., 204 S.C. 247, 29 S.E.2d 196, 198 (1944).

The Lawyer's motion claims no negligence cause of action is available against them "because Plaintiff is a non-client, third party to whom Defendants do not owe a duty." (Def. Motion to Dismiss, p. 1). South Carolina law does not support the Lawyers' theory. "A tortfeasor may be subjected to tort liability for injury to a third party arising out of the tortfeasor's contractual relationship with another, despite the absence of privity between the tortfeasor and the third party." Barker v. Sauls, 289 S.C. 121, 122, 345 S.E.2d 244, 244 (1986) (citing Terlinde v. Neely, 275 S.C. 395, 271 S.E.2d 768 (1980)). In addition, "[t]he tortfeasor's liability exists independently of contract, and rests upon the tortfeasor's duty to exercise due care." Id. (citing Edward's of Byrnes Downs v. Charleston Sheet Metal Co., 253 S.C. 537, 172 S.E.2d 120 (1970)). In Barker, the Supreme Court explained:

> The key inquiry is what duty, if any, is owed by the tortfeasor to the third party. It is essential to liability for negligence that the parties have some relationship recognized by law to support the duty owed by the tortfeasor. This duty may be derived from the tortfeasor's contractual relationship with another.

Id. (internal citations omitted).

> An essential element in a negligence action is the existence of a legal duty of care owed by the defendant to the plaintiff. The court must determine, as a matter of law, whether the law recognizes a particular duty. If there is no duty, then the defendant in a negligence action is entitled to judgment as a matter of law.

[1] Beginning on page 8 of the Complaint there are several errors on the auto-paragraph numbering, which caused duplicate paragraph numbers.

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> Generally, there is no formula for determining duty; a duty is not sacrosanct in itself but only an expression of the sum total of those considerations of policy which lead the law to say that a particular plaintiff is entitled to protection.

Shaw v. Psychemedics Corp., 426 S.C. 194, 197-98, 826 S.E.2d 281, 282-83 (2019) (internal quotes and citations omitted).

The Court should deny the Lawyers' motion to dismiss because the Verified Complaint states facts sufficient to constitute a cause of action for negligence.

II. No expert affidavit is necessary to support the general negligence claims in the Verified Complaint because there are no allegations of "professional negligence" against Defendants.

The Verified Complaint does not allege a client-lawyer relationship between the Lawyers and Plaintiff and does not allege the Lawyers fell below the standard of care in providing legal professional services to or for the benefit of Plaintiff. Because there are no allegations of "professional negligence," Plaintiff's claims are not within the purview of S.C. CODE ANN. § 15-36-100(B), which requires an expert affidavit to support "an action for damages alleging professional negligence against a professional licensed by or registered with the State of South Carolina[.]" Cf., Swanigan v. Am. Nat. Red Cross, 313 S.C. 416, 419 (1993) (claims against blood collection agency not within the scope of statute of limitations applicable to licensed healthcare providers).

The Court should deny the Lawyers' motion to dismiss because the Verified Complaint does not allege the Lawyers were in a client-lawyer relationship with Plaintiff or professionally negligent in providing legal services to Plaintiff. No expert affidavit of merit was necessary to be filed with the Complaint.

III. The Complaint states facts sufficient to constitute a cause of action for Fraud and for Constructive Fraud because allegations of a confidential or fiduciary relationship are unnecessary to support a claim or Fraud, Constructive Fraud, or Negligent Misrepresentation.

South Carolina law does not require allegations of a confidential or fiduciary relationship to support a claim for Fraud, Constructive Fraud, or Negligent Misrepresentation.

The South Carolina Court of Appeals made the following analysis on the proof requirements for claims for fraud, constructive fraud, and negligent misrepresentation:

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Plaintiff independently communicated with Lawyers' client

[Fraud]

To sustain a claim of fraud, all of the following elements must be proven: (1) a representation; (2) its falsity; (3) its materiality; (4) either knowledge of its falsity or reckless disregard of its truth or falsity; (5) intent that the representation be acted upon; (6) the hearer's ignorance of its falsity; (7) the hearer's reliance on its truth; (8) the hearer's right to rely thereon; and (9) the hearer's consequent and proximate injury.

The right to rely must be determined in light of the plaintiffs (sic.) duty to use reasonable prudence and diligence under the circumstances in identifying the truth with respect to the representations made to him. …. A party may not rely upon a misstatement of fact when the truth is easily within his reach. It is the policy of the courts not only to discourage fraud, but also to discourage negligence and inattention to one's own interests. However, a party may rely on representations without making further inquiry when a fiduciary or confidential relationship exists between the parties.

[Constructive Fraud]

To establish constructive fraud, all elements of actual fraud except the element of intent must be established. Neither actual dishonesty of purpose nor intent to deceive is an essential element of constructive fraud while intent to deceive is an essential element of actual fraud. Actual fraud is distinguished from constructive fraud by the presence or absence of the intent to deceive. However, in a constructive fraud case, where there is no confidential or fiduciary relationship, and an arm's length transaction between mature, educated people is involved, there is no right to rely.

[Negligent Misrepresentation]

In a negligent misrepresentation action, a plaintiff must prove the following: (1) the defendant made a false representation to the plaintiff, (2) the defendant had a pecuniary interest in making the statement, (3) the defendant owed a duty of care to see that he communicated truthful information to the plaintiff, (4) the defendant breached that duty by failing to exercise due care, (5) the plaintiff justifiably relied on the representation, and (6) the plaintiff suffered a pecuniary loss as the proximate result of his reliance on the representation.

Armstrong v. Collins, 366 S.C. 204, 218-220, 621 S.E.2d 368, 375 (Ct. App. 2005) (internal quotes and citations omitted).

In reviewing the Lawyers' Rule 12(b)(6) motion, Plaintiff's "right to rely" allegations in the Complaint must be taken as true. See (Complaint, ¶¶ 12, 16, 18-19, 21, 24-26, 31,

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37, 42, and 44). Where evidence or inferences exist to support the existence of Plaintiff's right to rely, the right to rely is a question of fact for the jury; and the Court must deny motions for dismissal under Rule 12(b)(6) regarding causes of action for fraud, constructive fraud, and negligent misrepresentation. See Armstrong v. Collins, 366 S.C. at 218, 621 S.E.2d at 375.

Plaintiff's complaint alleges Defendants' issuance of letters of protection and other representations resulted in Plaintiff's trust or reliance upon the statements of Defendants as lawyers for the client/patient. The existence of the letters of protection, which the Lawyers cannot and do not deny, give rise to an inference that the requisite evidence exists to establish a confidential relationship between Plaintiff and Defendants, which at this stage of pleading, justifies Plaintiff's "right to rely" necessary for fraud and constructive fraud and negligent misrepresentation claims. See Chapman v. Citizens and Southern Nat. Bank of South Carolina, 395 S.E.2d 446, 451, 302 S.C. 469, 478 (Ct. App. 1990)("… a confidential or fiduciary relationship exists when one reposes a special confidence in another so that the latter, in equity and good conscience, is bound to act in good faith and with due regard to the interest of the one reposing the confidence"(internal citation omitted)).

The Verified Complaint alleges the Lawyers made representations, assurances and promises to pay regarding liability coverage of $1,100,000 available to pay for costs of elective surgical procedures for patient/client of the parties. See (Complaint, ¶¶ 1, 11, 16, and 19). The Verified Complaint alleges the Lawyers, while aware of the promises to pay, representations and assurances they made regarding liability coverage of $1,100,000 available to pay for costs of elective surgical procedures for patient/client of the parties; never corrected those representations, assurances and promises to pay for all elective surgical procedures from liability coverage of $1,100,000. See (Complaint, ¶¶ 21 and 25).

The Verified Complaint alleges the Lawyers represented there was $1,100,000 in available insurance coverage for medical expenses incurred by Plaintiff's treatments to the Lawyers' client; and alleges the Lawyers owed Plaintiff duties to investigate and ascertain the amount of insurance coverage available to the Lawyers' client before making assurances and representations about the amount of insurance coverage

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available. The allegations in the Verified Complaint state facts sufficient to constitute causes of action for Fraud, Constructive Fraud, and Negligent Misrepresentation. The Court should reject the Lawyers' arguments and deny the Lawyers' Motion to Dismiss.

IV. The Complaint states facts sufficient to constitute a cause of action for Unjust Enrichment because it alleges the Lawyers received a "non-gratuitous benefit" by way of Plaintiff's medical services enhanced the settlement value of the Lawyer's client's claim thereby increasing the fees the Lawyers would earn.

Plaintiff's Complaint states the Lawyers' client received surgeries that enhanced the value of the claims the Lawyers were prosecuting without Plaintiff being compensated for those surgeries. The enhancement of the value of the claims performed at the Lawyers' request are either explicitly and plainly a non-gratuitous benefit conferred upon or realized by the Lawyers; or draws the inference that as the Lawyers for the client/patient, Plaintiff's performance of surgeries without being paid full value for those surgeries serviced as non-gratuitous benefit conferred upon or realized by the Lawyers. See Dema v. Tenet Physician Servs.-Hilton Head, Inc., 383 S.C. 115, 123, 678 S.E.2d 430, 434 (2009) ("A party may be unjustly enriched when it has and retains benefits or money which in justice and equity belong to another."); id. ("Unjust enrichment is an equitable doctrine which permits the recovery of that amount the defendant has been unjustly enriched at the expense of the plaintiff."); Barrett v. Miller, 283 S.C. 262, 265, 321 S.E.2d 198, 199 (Ct. App. 1984) ("Unjust enrichment" is an equitable doctrine, akin to restitution, which permits the recovery of that amount the defendant has been unjustly enriched at the expense of the plaintiff).

The Court can reasonably infer from the allegations in Plaintiff's Verified Complaint, the enhancement Plaintiff's surgeries added to the value of the personal injury claim the Lawyers were prosecuting. Justice and equity require the Lawyers compensate Plaintiff for bestowing a benefit to the Lawyers by enhancing the value of the personal injury claim they were prosecuting with the surgeries performed on the Lawyer's client.

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V. The Complaint states facts sufficient to constitute a cause of action for Breach of Contract Accompanied by a Fraudulent Act because it alleges a breach of "Letters of Protection" contracts, the Lawyers' fraudulent intent as to how the Lawyers breached the LOPs, and the Lawyers' fraudulent act in concealing the true amount of insurance coverage.

This Court should deny the Lawyers' motion to dismiss because Plaintiff's allegations are presumed true for the purposes of this motion.

"In order to maintain a claim for breach of contract accompanied by fraudulent act, a plaintiff must prove three elements: (1) a breach of contract; (2) fraudulent intent relating to the breaching of the contract, not merely to its making; and (3) a fraudulent act accompanying the breach." Hotel & Motel Holdings, LLC v. BJC Enterprises, LLC, 414 S.C. 635, 654, 780 S.E.2d 263, 273-74 (Ct. App. 2015) (citing Floyd v. Country Squire Mobile Homes, Inc., 287 S.C. 51, 53-54, 336 S.E.2d 502, 503-04 (Ct. App.1985)). The Verified Complaint states facts establishing all three elements of this claim.

A. Breach of Contract.

The Verified Complaint alleges the existence and the Lawyers' breach of "Letter of Protection" contracts. See (Verified Complaint, ¶¶ 11-13, 22-24, 31, 33-34, and 37). The Lawyers did not honor the "Letters of Protection" where they promised to ""to protect any portion of your bill not paid by private health insurance," as alleged in ¶ 22 and Exhibit 6 to the Verified Complaint. The Verified Complaint alleges the Lawyers "have refused to pay the outstanding balance of $125,409.25." See (Verified Complaint, ¶ 34).

B. Fraudulent Intent Relating to the Breach.

The Verified Complaint alleges in Paragraph 21 the Lawyers never explained to Plaintiff "there were concerns about insurance coverage," and alleges in Paragraph 25 the Lawyers failed "to explain that the available insurance coverage was less than the $1,100,000 mentioned in the Lawyers' January 21, 2019 email or that they would not honor the LOP." One can reasonably infer from the allegations in the Verified Complaint that the Lawyers' fraudulent intent relating to the breach is based on their desire to have Plaintiff perform the surgical procedures thereby increasing the amount of damages available for the personal injury claim thereby increasing the likelihood of a larger settlement and a larger fee for the Lawyers.

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C. Fraudulent Act.

The Verified Complaint alleges the Lawyers represented "'other arrangements' had been made such that CAROLINA NEUROSURGERY would collect the full value of the Lawyers' client's elective treatments from the funds the Lawyers represented would be provided by various liability insurance policies that would cover the Lawyers' client's personal injury claims in an amount over $1,100,000." See (Verified Complaint, ¶ 16). "The Lawyers never explained to CAROLINA NEUROSURGERY, Dr. Highsmith, or their staff before Dr. Highsmith performed the first and second surgeries on the Lawyers' client to explain that the available insurance coverage was less than the $1,100,000 mentioned in the Lawyers' January 21, 2019 email or that they would not honor the LOP." See (Verified Complaint, ¶ 25). The inferences from these allegations are fraudulent acts by Defendants. This Court should deny the Lawyers' motion to dismiss because the Verified Complaint states facts sufficient to constitute a cause of action for Breach of Contract Accompanied by Fraudulent Act.

The Court cannot consider the factual allegations asserted in the Lawyers' Motion to Dismiss claiming "Defendants have attempted to tender payment to Plaintiff, but Plaintiff wrongfully refused it." See (Defendants' motion p. 2, ¶ (5)). The Court can consider only the allegations in the Verified Complaint in motion under Rule 12(b)(6), SCRCP.

VI. The Complaint states facts sufficient to constitute a cause of action for Violation of the South Carolina Unfair Trade Practices Act because it alleges the Lawyers engaged in unfair and deceptive acts or practices while engaged in trade or commerce in South Carolina.

This Court should deny the Lawyers' motion to dismiss because the allegations in the Verified complaint states facts sufficient to support a cause of action under the South Carolina Unfair Trade Practices Act based on the unfair and deceptive acts alleged in their deceptive and false representations leading Plaintiff to provide elective surgery procedures to the Lawyers' client knowing Plaintiff was an out-of-network healthcare provider outside of the client's healthcare coverage.

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VII. The Court cannot consider the Lawyers' factual allegations stated in their Motion to Dismiss.

The Court cannot consider the factual allegations asserted in the Lawyers' Motion to Dismiss claiming "Defendants have attempted to tender payment to Plaintiff, but Plaintiff wrongfully refused it." See (Defendants' motion p. 2, ¶ (5)). The Lawyers' make improper factual allegations as part of their argument (6), which states:

> (6) To the extent the Letters of Protection sent by D&M constitute valid, binding contracts obligating Defendants to pay Plaintiff out of settlement proceeds recovered for Defendants' client, Defendants have attempted to tender such payment to Plaintiff, and Plaintiff refused it. Therefore, because Plaintiff's wrongful refusal has impeded Defendants in the performance of their obligation, Defendants are entitled to judgment as a matter of law that they have not breached the Letters of Protection.

See (Defendants' motion p. 2, ¶ (6)).

The Court can consider only the allegations in the Verified Complaint in motion under Rule 12(b)(6), SCRCP. The Court must disregard the Lawyers' factual allegations in their Motion; the Court can consider only the allegations in the Verified Complaint.

CONCLUSION

This Court should deny the Lawyers' Motion based on the allegations in the Verified Complaint, the South Carolina Rules of Civil Procedure, and the common law of South Carolina.

Respectfully submitted,

s/ Thomas A. Pendarvis

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February 23, 2022

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STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON Carolina Neurosurgery & Orthopaedics, Inc., Plaintiff, vs. Michael A. Maucher, Esq. and DeLuca & Maucher, LLP, Defendants.	IN THE COURT OF COMMON PLEAS IN THE NINTH UDICIAL CIRCUIT CASE NO.: 2021-CP-10-03379 **MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS**

NOW COME Defendants Michael A. Maucher, Esq. ("Maucher") and Deluca & Maucher, LLP ("D&M") (collectively, "Defendants"), by and through their undersigned counsel and hereby submit this Memorandum in Support of Defendants' Motion to Dismiss, filed on October 22, 2021 ("Defendants' Motion"). In addition to any arguments made in Defendants' Motion, and in further support thereof, Defendants would respectfully show this Court as follows:

INTRODUCTION

This case arises from Plaintiff's failure to exercise due diligence and failure to follow its own financial policy before proceeding with approximately $125,000.00 in surgical treatment for one of Defendants' clients who was injured in a motor vehicle collision on December 14, 2018. Contrary to the allegations in Plaintiff's Complaint, Defendants did not become aware that Plaintiff and its surgeon, Dr. Highsmith, were "out of network" healthcare providers under Defendants' client's private health insurance until long after Plaintiff had rendered medical services to their client.

Not permitted in a Motion to Dismiss

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Further, despite repeated instructions from both Defendants and their client regarding billing insurance for Plaintiff's services, Plaintiff never attempted to: (1) confirm its network status with Defendant's client's health insurance; or (2) submit the proposed procedures to the client's health insurance for pre-approval before proceeding with the surgeries at issue. Plaintiff also never attempted to submit claims for payment to the client's health insurance following each of the surgeries, as is Plaintiff's practice under its financial policy. Moreover—despite Defendants' offer to pay Plaintiff out of the $30,000 settlement proceeds recovered for their client—Plaintiff not only rejected such offer, but it brought a debt collection action against Defendants' client in the Berkeley County, South Carolina Court of Common Pleas.[1]

FACTUAL BACKGROUND

On December 14, 2018, Defendants' client ("Client") was injured in a motor vehicle collision. Shortly thereafter, he retained Defendants to pursue claims against the at-fault driver. As Client was a prior surgery patient of Plaintiff, he selected Plaintiff for surgical treatment of his injuries arising from the accident. Dr. Jason M. Highsmith, MD ("Highsmith") performed the procedures. On December 20, 2018, at Client's request, D&M sent Plaintiff a letter of protection ("December 20, 2018 LOP"), in which D&M agreed to protect any claim by Plaintiff for the cost of Client's treatment out of any settlement proceeds arising from the accident. The December 20, 2018 LOP is attached to Plaintiff's Complaint as Exhibit 1 and is incorporated herein by reference.

On January 3, 2019, Client executed Plaintiff's Financial Policy ("Financial Policy"), which is attached to Plaintiff's Complaint as Exhibit 2 and is incorporated herein by reference. The Financial Policy provided that Plaintiff would submit claims for payment under a patient's

[1] *Carolina Neurosurgery and Orthodontics, Inc. v. Scott Demaskey*, 2021CP0801088.

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primary health insurance. At the time, Client had primary health insurance through Blue Cross/Blue Shield, and he confirmed his insurance information with Plaintiff's office staff on several occasions. On January 16, 2019, Kiara Goodwine ("Goodwine"), an employee in Plaintiff's office, contacted D&M to request information regarding the at-fault driver's liability policy limits. On January 21, Tina Bennett, a paralegal with D&M ("Bennett") responded that the at-fault carrier was from North Carolina and would not disclose policy limits without a medical authorization from Client.

However, Bennett informed Goodwine that Client carried a total of $1,100,000 in accident coverage under two additional insurance policies. On the same day, Bennett also emailed Goodwine and informed her that based upon the severity of Client's injury and his pre-existing injuries, all of his treatment would need to be filed with his private health insurance and should not proceed under a letter of protection. Goodwine acknowledged receipt of the email and Bennett's instructions. Accordingly, as of January 21, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance. Said emails are attached to Plaintiff's Complaint as Exhibit 5 and are incorporated herein by reference.

On March 7, 2019, D&M sent a revised letter of protection to Plaintiff ("March 7, 2019 LOP"), stating that D&M would protect whatever amounts Client's private health insurance did not pay out of the proceeds of any settlement of Client's personal injury claim. Bennett's email containing the March 7, 2019 LOP emphasized that "[t]his LOP covers whatever is NOT paid by private health insurance." Pltf.'s Compl. at Ex. 6 (emphasis in original). Therefore, as of March 7, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance first before seeking payment under the March 7, 2019 LOP. Despite D&M's prior instructions and the express language of the March 7, 2019 LOP, Plaintiff never: (1) attempted to

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confirm its network status with Client's health insurance carrier before rendering surgical services; (2) notified D&M or Client of any network issues affecting coverage before rendering surgical services; (3) or attempted to file claims for payment with Client's private health insurance, as is required under Plaintiff's Financial Policy.

Highsmith performed Client's first surgery—a C6-7 ACDF surgery—on March 15, 2019 ("First Surgery") at a cost of $62,451.87. Highsmith's operative report from the First Surgery is attached to Plaintiff's Complaint as Exhibit 7 and is incorporated herein by reference. As Client's personal injury case developed, it was determined that: (1) the at-fault driver did not have sufficient insurance coverage to fully cover Client's medical treatment; (2) one of Client's other additional policies was inapplicable; and (3) the other additional policy was subject to subrogation and only applicable after Client's primary private health insurance had been exhausted.

On April 29, 2019, D&M notified Plaintiff via email of the foregoing issues, stating:

> "Because the at-fault party only had $30,000.00 and [Client's] Underinsured Motorist Coverage does not apply, ALL of the treatment [Client] has received (and will continue to receive) must be filed under his private health insurance. We cannot honor anymore treatment under a Letter of Protection. Please note [Client's] file accordingly."

Pltf.'s Compl. at ¶ 29 (emphasis in original). On May 2, 2019, Highsmith performed additional surgery on Client at an approximate cost of $65,000.00 ("Second Surgery"). *See* Pltf.'s Compl. at ¶ 31. Despite receiving explicit instructions regarding claim submission and payment on several occasions prior to both surgeries, Plaintiff never attempted to file claims for Client's surgical services with Client's private health insurance. Instead, Plaintiff waited until around November 2, 2020—almost one year after the completion of Client's treatment—to send Client a bill for surgical services in the amount of $125,409.28. *See* Pltf.'s Compl. at Ex. 3.

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Because Client has been unable to pay for Plaintiff's services, Plaintiff initiated a debt collection action against him on May 21, 2021. Further, Plaintiff has demanded payment from D&M under the March 7, 2019 LOP. While D&M does not believe the March 7, 2019 LOP constitutes a valid, binding contract between it and Plaintiff, D&M has nevertheless attempted to tender payment to Plaintiff out of the settlement proceeds, and Plaintiff refused it. Moreover, the settlement proceeds are currently being held in D&M's trust account, and Defendants will not receive any of the funds upon resolution of this matter.

Despite Defendants' offer to pay Plaintiff out of the settlement proceeds, Plaintiff filed this action on July 22, 2021. Plaintiff's Complaint asserts causes of action against Defendants for (1) Breach of Contract; (2) Breach of Contract Accompanied by Fraudulent Act; (3) Violation of the SC Unfair Trade Practices Act; (4) Fraud; (5) Constructive Fraud; (6) Unjust Enrichment; and (7) Negligence. For the following reasons, Plaintiff's Complaint should be dismissed with prejudice because it fails to state facts sufficient to constitute the above causes of action.

PROCEDURAL STANDARD

When ruling on a Motion to Dismiss, "[t]he circuit court may dismiss a claim when the defendant demonstrates the plaintiff's 'failure to state facts sufficient to constitute a cause of action' in the pleadings filed with the court." *Hambrick v. GMAC Mortg. Corp.*, 370 S.C. 118, 121, 634 S.E.2d 5, 7 (Ct. App. 2006) (*citing FOC Lawshe Ltd. P'ship v. Int' l Paper Co.*, 352 S.C. 408, 412, 574 S.E.2d 228, 230 (Ct.App.2002)). Further, the trial court must base its ruling solely on allegations set forth in the complaint. *Bergstrom v. Palmetto Health Alliance*, 358 S.C. 388, 395, 596 S.E.2d 42, 45, (2004). However, "[i]f on a motion…to dismiss for failure of the pleading to state facts sufficient to constitute a cause of action, matters outside the pleading are

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presented to and not excluded by the Court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56." Rule 12(b), SCRCP.

ARGUMENT

I. Plaintiff's Complaint fails to state facts sufficient to constitute a cause of action against Defendants for Negligence because Defendants did not owe Plaintiff a duty.

Plaintiff's Complaint fails to allege facts sufficient to support a cause of action for Negligence against Defendants because, as a matter of law, Defendants owed no duty of care to Plaintiff. To establish a cause of action for negligence, a plaintiff must show: (1) the defendant owes a duty of care to the plaintiff; (2) the defendant breached that duty by a negligent act or omission; (3) the defendant's breach was the actual and proximate cause of the plaintiff's injury; and (4) the plaintiff suffered an injury or damages. *Roddey v. Wal-Mart Stores East, LP*, 415 S.C. 580, 589, 784 S.E.2d 670, 675 (2016). The existence of a legal duty is an indispensable element of Negligence. *See, e.g.*, *S.C. Elec. & Gas Co. v. Utilities Const. Co.*, 244 S.C. 79, 88, 135 S.E.2d 613, 617 (1964) ("The breach of a legal duty is essential to negligence…Without a violation of such a legal duty, there is no negligence.").

Moreover, for a duty to arise in the context of an attorney's professional activity, an attorney-client relationship must generally exist between the attorney and the party asserting a claim for Negligence. *See Holy Loch Distributors, Inc. v. Hitchcock*, 340 S.C. 20, 26, 531 S.E.2d 282, 285 (2000) (stating that in a legal malpractice and negligence action, a plaintiff must establish, among other elements, "the existence of an attorney-client relationship."). "Generally, "an attorney is immune from liability to third persons arising from the performance of his professional activities as an attorney on behalf of and with the knowledge of his client.' " *Argoe v. Three Rivers Behavioral Center and Psychiatric Solutions*, 388 S.C. 394, 400, 697 S.E.2d 551,

554 (2010) (*citing Pye v. Estate of Fox*, 369 S.C. 555, 564, 633 S.E.2d 505, 509 (2006). Where a plaintiff in a negligence action against an attorney is not the attorney's client, no duty of care exists. *See Argoe*, 388 S.C. at 400, 697 S.E.2d at 554 (holding that the appellant "was not owed a duty of care" because she "was not Respondent's client.").

Here, Plaintiff alleges Defendants owed Plaintiff a duty "to investigate and ascertain the amount of insurance coverage available to [Defendants'] Client before making assurances and representations to [Plaintiff] about the amount of insurance coverage available." Pltf.'s Compl. at ¶ 77. However, Plaintiff has never been Defendants' client with regard to this matter, nor does its Complaint allege an attorney-client relationship existed between Plaintiff and Defendants. As the Complaint makes clear, Plaintiff is merely a third-party medical services provider that provided surgical treatment for Defendants' Client in the past, *See id.* at ¶ 7, and that provided additional surgical treatment during Defendants' representation of their Client following his December 14, 2018 accident. *See id.* at ¶¶ 13, 17, 26, 31, and 33.

Further, Defendants' communications with Plaintiff and its staff were made in the course and scope of their representation of Client and pursuit of his personal injury claim against the at-fault driver. *See, e.g.,* December 20, 2018 LOP and March 7, 2019 LOP (identifying Defendants' Client, setting forth the date of Client's accident, and addressing protection of claims Plaintiff may have "out of any settlement proceeds we may receive arising out of [Client's accident]"); Pltf.'s Compl. at Ex. 4, Jan. 21, 2019 email from Tina Bennett to Kiara Goodwine ("[Client] has advised our office that he will require surgery. Based upon the serious nature of his injury, and his pre-existing injuries, we would respectfully request that all of his treatment be filed with his private health insurance company.").

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Plaintiff's Complaint fails to allege any facts to indicate any of Defendants' alleged statements were made outside the course and scope of Defendants' representation of Client. Therefore, because at all relevant times herein Plaintiff was not Defendants' client, and Defendants' statements to Plaintiff were made in the course and scope of their professional activities on behalf of Client and with his knowledge, Defendants did not owe Plaintiff a duty of care as a matter of law. Accordingly, Plaintiff's cause of action for Negligence must be dismissed with prejudice, pursuant to Rule 12(b)(6), SCRCP.

II. Plaintiff's Complaint is subject to dismissal for failure to include an affidavit of an expert witness.

Pursuant to S.C. Code Ann. § 15-36-100(B), "in an action for damages alleging professional negligence against a professional licensed by or registered with the State of South Carolina and listed in subsection (G)…the plaintiff must file as part of the complaint an affidavit of an expert witness which must specify at least one negligent act or omission claimed to exist and the factual basis for each claim based on the available evidence at the time of the filing of the affidavit." The statute further provides that "[i]f an affidavit is not filed … and the defendant against whom the affidavit should have been filed alleges, by motion to dismiss filed contemporaneously with its initial responsive pleading that the plaintiff has failed to file the requisite affidavit, the complaint is subject to dismissal for failure to state a claim." S.C. Code Ann. § 15-36-100(C)(1). The statute expressly applies to actions for professional negligence against attorneys at law. *See* S.C. Code Ann. § 15-36-100(G)(2).

In 2005, the South Carolina General Assembly enacted tort reform legislation to "establish standards for expert witnesses in professional malpractice actions" and to "filter frivolous claims" against professionals by requiring the contemporaneous filing of an expert

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affidavit identifying at least one negligent act or omission. *See generally*, *Ranucci v. Crain*, 409 S.C. 493, 763 S.E.2d 189 (2014). To that end, South Carolina appellate courts have affirmed dismissals of professional negligence actions where a plaintiff failed to include the required expert affidavit with its filed complaint.

For example, in *H&H of Johnston, LLC v. Old Republic Nat'l Title Ins. Co.*, the Court of Appeals affirmed an order dismissing the case due to plaintiff's failure to file an expert affidavit. 405 S.C. 469, 748 S.E.2d 72 (2013). The Court of Appeals held that the defendant in that case was acting in his professional capacity as a real estate closing attorney, when he provided legal opinions to his client, the plaintiff, regarding certain aspects of the plaintiff's contemplated real estate purchase. *See id.* at 474, 748 S.E.2d at 74. As a result, the court found "the plaintiff must file an affidavit of an expert witness in support of the complaint specifying particular negligent acts or omissions of the attorney," *id.*, and the court affirmed the trial court's grant of summary judgment to the defendant based upon the plaintiff's failure to do so. *See id.*

As discussed above, Defendants' alleged statements, actions, and/or omissions in this matter all arose in the performance of their professional activities on behalf of Client. Defendants were specifically retained to pursue personal injury claims arising from the December 14, 2018 accident on behalf of Client. In doing so, Defendants documented the costs and monitored the progress of the medical services provided to client as a result of the accident. Clearly, such actions taken in support of a client's claim, and any statements made in furtherance thereof, fall squarely within the professional competency of attorneys.

Moreover, the representation of a personal injury client, the investigation, analysis, and negotiation of claims, the safeguarding of client funds and property (including the issuance of letters of protection to client creditors, where appropriate) all constitute the practice of law,

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requiring special knowledge, skill, experience, and licensure. *See State v. Buyers Service Co.*, 292 S.C. 426, 430, 357 S.E.2d 15, 17 ("The practice of law is not confined to litigation, but extends to activities in other fields which entail specialized legal knowledge and ability."). *See also, In re Duncan*, 83 S.C. 186, 189, 65 S.E. 210, 211 (1909) (holding the practice of law includes "…all advice to clients, and all action for them in matters connected with the law."); S.C. Code Ann. § 40-5-310 ("No person may either practice law or solicit the legal cause of another person…in this State unless he is enrolled as a member of the South Carolina Bar pursuant to applicable court rules").

Further, the professional conduct of all attorneys, including Defendants in this case, is governed by many specialized rules promulgated by the State Supreme Court—namely the *South Carolina Rules of Professional Conduct*, Rule 407, SCACR. Such rules, as well as common law standards of care relating to attorney conduct, certainly fall outside the ambit of common knowledge and experience of the general public.

Accordingly, for the foregoing reasons, Defendants' alleged actions and/or omissions forming the basis of Plaintiff's claims were undertaken in their professional capacity as attorneys for Client, and the affidavit of an expert witness with sufficient knowledge and skill is required to evaluate Defendants' conduct. Therefore, pursuant to S.C. Code Ann. § 15-36-100(B), Plaintiff was required to file with its Complaint an affidavit of an expert witness specifying at least one negligent act or omission on the part of Defendants claimed to exist and the factual basis for each claim based on the available evidence at the time of the filing of the affidavit. Plaintiff's failure to do so mandates dismissal with prejudice of its Negligence claim under S.C. Code Ann. § 15-36-100(C)(1) and South Carolina common law.

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III. Plaintiff failed to allege essential elements of Fraud and Constructive Fraud.

Plaintiff's claims for Fraud and Constructive Fraud are subject to dismissal because Plaintiff failed to allege facts sufficient to establish it had a right to rely on the truth of any representations made to it in connection with this matter. "To establish a cause of action for fraud, the following elements must be proven by clear, cogent, and convincing evidence: (1) a representation of fact; (2) its falsity; (3) its materiality; (4) either knowledge of its falsity or a reckless disregard of its truth or falsity; (5) intent that the representation be acted upon; (6) the hearer's ignorance of its falsity; (7) the hearer's reliance on its truth; (8) the hearer's right to rely thereon; and (9) the hearer's consequent or proximate injury." *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 50, 691 S.E.2d 135, 149 (2010).

Further, pursuant to Rule 9(b), SCRCP, "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity." "A complaint is fatally defective if it fails to allege all nine elements of fraud." *Ardis v. Cox*, 314 S.C. 512, 515, 431 S.E.2d 267, 269 (Ct. App. 1993). Where the complaint omits allegations on any element of fraud, the trial court should grant the defendant's motion to dismiss the claim. *Id.*

a. Availability of Insurance Coverage.

Plaintiff alleges Defendants knowingly or recklessly made false representations of fact as to: (1) "the amount of insurance coverage available to pay for medical/surgical services [Plaintiff] planned to provide to [Client];" and (2) "[Defendants'] intent to pay [Plaintiff] from any recovery [Defendants] obtained on behalf of [Client]." *See* Pltf.'s Compl. at ¶¶ 47-53. However, while Plaintiff generally alleges it had a right to rely on such representations, *See id.* at ¶ 57, its Complaint fails to state with particularity any facts supporting this purported right, as required by Rule 9(b), SCRCP and South Carolina case law.

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"The right to rely must be determined in light of the plaintiff's duty to use reasonable prudence and diligence under the circumstances in identifying the truth with respect to the representations made to him." *Regions Bank v. Schmauch*, 354 S.C. 648, 672, 582 S.E.2d 432, 445 (Ct. App. 2003). "Moreover, there is no right to rely, as required to establish fraud, where there is no confidential or fiduciary relationship and there is an arm's length transaction between mature, educated people. This is especially true in circumstances where one should have utilized precaution and protection to safeguard his interests." *Id*.

Here, no confidential or fiduciary relationship existed between Plaintiff and Defendants, and Plaintiff's Complaint does not allege otherwise. As discussed above, Plaintiff was not Defendants' client; it was merely a third-party provider of medical services to Client. At most—although Defendants deny the LOP's constituted valid contracts, they will assume so for the purposes of this argument—there may have been an arm's length transaction between the parties. Accordingly, Plaintiff was not entitled, by virtue of the parties' relationship to one another, to rely on Defendants' representations as to insurance coverage or intent to pay. Instead, Plaintiff was under an affirmative duty to use reasonable prudence and diligence to attempt to discover the truth of the representations.

Plaintiff alleges that by January 3, 2019—the date on which Client executed Plaintiff's Financial Policy—all parties involved knew Plaintiff and Highsmith were "out-of-network" healthcare providers under Client's private health insurance. Pltf.'s Compl. at ¶ 14. Defendants deny this allegation, but they will take it as true for purposes of their Motion. While Bennett initially emailed Goodwine on January 21, 2019 and indicated "we are not concerned that there will be enough overall coverage to pay the claim," *id.* at Ex. 4, she followed up the same day and notified Goodwine that all of Client's surgical treatment was to be filed with his private health

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insurance company, and that treatment should not proceed under an assignment or letter of protection. *See id*. Goodwine acknowledged receipt of Bennett's instructions and did not indicate there would be any issues with proceeding in the instructed manner. *See id*.

Accordingly, as of January 21, 2019—approximately two (2) months before Client's First Surgery—Plaintiff had actual notice that: (1) the December 20, 2018 LOP would no longer be honored; (2) Defendants did not intend to protect Plaintiff's claims out of any settlement proceeds from Client's personal injury claim; and (3) Plaintiff should file all claims for payment with Client's private health insurance company. Further, Bennett's email to Goodwine did not indicate any claims could or should be filed with Client's underinsured motorist carrier or his occupational accident carrier. *See id*.

Assuming, as Plaintiff alleges, that it knew it was an "out-of-network" provider for which claims would not be paid under Client's private health insurance policy, it should have refused Bennett's instructions to file claims with Client's private health insurance company. Further—as of January 21, 2019—because Plaintiff knew Defendants did not intend to protect its claims out of any settlement proceeds, and it supposedly knew there would be a lack of coverage under Client's private health insurance policy, Plaintiff should have known the only potential avenue for payment would have been through Client's underinsured motorist and/or occupational accident policies.

Plaintiff, in the exercise of reasonable diligence, could and should have taken steps to obtain written confirmations of coverage from the underinsured motorist and occupational accident carriers themselves before furnishing costly surgical and other medical services to Client. In doing so, Plaintiff could have discovered the potential coverage issues and referred Client to an appropriate "in-network" surgeon for further treatment. However, Plaintiff instead

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chose to rely solely on Bennett's first January 21, 2019 email to Goodwine—expressing only an opinion on available coverage—which, as discussed above, Plaintiff had no right to rely on.

Accordingly—because Plaintiff had no right to rely on Bennett's statement regarding the amount of insurance coverage available to pay for Client's medical and surgical expenses, and Plaintiff's Complaint fails to allege any other efforts undertaken by Plaintiff to protect its interests and discover the truth of the matter—Plaintiff's Fraud and Constructive Fraud claims fail as a matter of law and should be dismissed with prejudice.

b. The Letters of Protection.

As an initial matter—to the extent Plaintiff asserts claims for Fraud and Constructive Fraud in connection with Defendants' December 20, 2018 LOP, Plaintiff clearly had no right to rely on any statements contained therein because the letter was effectively revoked in Bennett's second January 21, 2019 email to Goodwine stating that treatment should not proceed under a letter of protection. Further, for purposes of Defendants' Motion only, the March 7, 2019 LOP at best constitutes a contract by which D&M agreed to "protect any portion of [Plaintiff's] bill ***not paid by private health insurance*** out of any settlement proceeds we may receive…" Pltf.'s Comp. at Ex. 6 (emphasis added). Stated differently, Plaintiff was required to seek payment from Client's private health insurance *before* making a claim to any settlement funds. First, as noted above, Plaintiff never attempted to submit claims for its services to Client's private health insurance carrier.

Second, Plaintiff has failed to allege with particularity any facts or circumstances indicating either that: (1) Defendants had no intention of paying Plaintiff under the March 7, 2019 LOP at the time they sent the letter to Plaintiff; or (2) the statements contained in the March 7, 2019 LOP were false at the time they were made. At most, such statements could possibly be

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construed as contractual promises of D&M. Without more, Defendants' alleged failure to pay Plaintiff under the March 7, 2019 LOP is insufficient to state valid claims for Fraud or Constructive Fraud. *See Davis v. Upton*, 250 S.C. 288, 291, 157 S.E.2d 567, 568 (1967) ("The general rule is that fraud must relate to a present or pre-existing fact, and ***cannot ordinarily be predicated on unfulfilled promises or statements as to future events***.") (emphasis added). *See also, id.*, 250 S.C. 288 at 293, 157 S.E.2d at 569 (holding that "[t]he mere breach of a contract does not constitute fraud."). Therefore, as Plaintiff's Fraud and Constructive Fraud claims relate to the March 7, 2019 LOP, they should also be dismissed with prejudice.

IV. Plaintiff's Complaint fails to state a valid claim for Unjust Enrichment.

Plaintiff's Unjust Enrichment claim fails as a matter of law and should be dismissed because Plaintiff has not specifically identified any valid, non-gratuitous benefit conferred upon or realized by Defendants in connection with this matter. The essential elements of unjust enrichment are: (1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by defendant of the benefit under conditions that make it inequitable for him to retain it without paying its value. *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 15 (Ct. App. 1988).

Moreover, speculative claims of future increased value are not a sufficient benefit to support an unjust enrichment claim. *See Bouchard v. Price*, 694 A.2d 670, 673 (R.I. 1997) (holding insufficient "profits that plaintiffs anticipate defendant might obtain by selling the rights to his story at some unspecified time in the future."). Here, Plaintiff alleges it provided surgical services to Client, Pltf.'s Compl. at ¶ 73, and that the provision of such services enhanced the settlement value of Client's claim. *Id.* at ¶74. These allegations are insufficient to support a valid claim for Unjust Enrichment for two reasons. First, as the Complaint itself admits, Plaintiff

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provided surgical and other medical services to ***Client***, not to Defendants. Therefore, while Plaintiff clearly conferred a benefit on Client, it did not confer any benefit on Defendants.

Second, similar to the potential for future profits in *Bouchard*, the potential enhancement in settlement value of Client's claim is too speculative to form the basis of a valid Unjust Enrichment claim. Plaintiff cannot rely on conjecture that as a result of its services, at some indeterminate point in the future, Client's claim ***may have been resolved*** for a larger amount, or that Defendants would somehow benefit therefrom. Further, Plaintiff has not alleged any facts to show: (1) whether and how the surgical services rendered to Client affected settlement negotiations, if at all; or (2) whether and how Defendants have realized a benefit based on a purported enhancement in settlement value of ***Client's claim***. Accordingly, Plaintiff has failed to plead facts sufficient to show it has conferred any benefit on Defendants, or that Defendants have realized any valid, non-speculative benefit as a result of the surgical services performed for Client. Therefore, the Court should dismiss Plaintiff's Unjust Enrichment claim with prejudice.

V. Plaintiff failed to state a valid claim for Breach of Contract Accompanied by a Fraudulent Act.

In order to state a claim for Breach of Contract Accompanied by a Fraudulent Act, a plaintiff "must plead facts establishing three elements: (1) a breach of contract; (2) fraudulent intent ***relating to the breaching of the contract and not merely to its making***; and (3) a fraudulent act ***accompanying the breach***." *Harper v. Ethridge*, 290 S.C. 112, 119, 348 S.E.2d 374, 378 (Ct. App. 1986) (emphasis added). Here, Plaintiff's claim fails for two primary reasons. First—even assuming the March 7, 2019 LOP is a valid contract and that Defendants' alleged failure to pay Plaintiff constitutes a breach thereof, which Defendants deny—Plaintiff

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has failed to allege facts establishing fraudulent intent specifically relating to Defendants' alleged breach of the March 7, 2019 LOP.

Plaintiff alleges Defendants breached the March 7, 2019 LOP by refusing to pay it any portion of the $30,000.00 in settlement funds recovered for Client. *See* Pltf.'s Compl. at ¶¶ 35, 39, 40-44. Based on the allegations in Plaintiff's Complaint, it appears Defendants' alleged refusal to pay occurred either in late 2020 or early 2021, after Plaintiff sent Client an invoice for its services on or around November 2, 2020. However, all of Plaintiff's allegations of fraud or fraudulent intent on the part of Defendants relate to Bennett's statements to Goodwine in January, 2019 regarding the availability of insurance coverage. Such statements were made approximately two months prior to the March 7, 2019 LOP. As Plaintiff alleges, "[Defendants] and [Plaintiff] ***entered*** [into] the LOP, with all parties knowing the availability of liability or other insurance coverage was a material term…," *id.* at ¶ 39. Therefore, Plaintiff's allegations relate to the making of the March 7, 2019 LOP, not its alleged breach approximately two years later.

Second, Plaintiff has not alleged any fraudulent acts by Defendants accompanying their purported failure to pay Plaintiff under the March 7, 2019 LOP. "[A] fraudulent act is any act characterized by dishonesty in fact, unfair dealing, or the unlawful appropriation of another's property by design." *Harper*, 290 S.C. at 119, 348 S.E.2d at 378. Here, Plaintiff's Complaint contains no allegations of any such dishonest representations of fact, unfair dealing, or unlawful appropriation of property on the part of Defendants. Indeed, as Plaintiff's admits, "[Defendants] have no explanation on why they have not paid [Plaintiff] the entire $30,000 from the recovery obtained for [Client]." Pltf.'s Compl. at ¶ 39. At most, the matters alleged in Plaintiff's Complaint may constitute a breach of contract. However, for the foregoing reasons, they are

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insufficient to support a valid claim for Breach of Contract Accompanied by a Fraudulent Act. Therefore, the Court should dismiss this claim with prejudice.

CONCLUSION

For the foregoing reasons, Plaintiff's Complaint fails to state facts sufficient to constitute causes of action for Breach of Contract, Breach of Contract Accompanied by Fraudulent Act, Fraud, Constructive Fraud, Unjust Enrichment, and Negligence. Pursuant to Rule 12(b)(6), SCRCP, Defendants respectfully request the Court to dismiss Plaintiff's claims with prejudice.

Further, Defendants specifically request the Court award Defendants reasonable attorneys' fees and costs incurred in pursuing Defendants' Motion to Dismiss, and for such other and further relief as the Court deems just and proper.

This 23rd day of February, 2022.

Respectfully submitted,

COPELAND, STAIR, KINGMA & LOVELL, LLP

By: *s/ Douglas W. MacKelcan*
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ELECTRONICALLY FILED - 2022 Jul 05 5:33 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, Defendants.	**PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS**

TO: DOUGLAS W MACKELCAN, ESQ. AND MICHAEL C. MASCIALE, ESQ., COUNSEL FOR DEFENDANTS:

Plaintiff respectfully files this Motion to Alter or Amend under Rule 59(e), SCRCP, to have the Court alter or amend its "Order On Defendants' Motion to Dismiss" ("the Order") granting in part and denying in part the Motion to Dismiss filed on behalf of Defendants, Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP (collectively "the Lawyers").

This Motion requests the Court amend the Order to remove a substantial majority of the "Findings of Fact" that were not included in the Court's email sent at 3:36 pm on June 9, 2022, instructing counsel for Defendants to prepare a proposed Order. The proposed Order was submitted to the Court on June 28, 2022, while the undersigned counsel for Plaintiff was under a Consent Order of Protection between June 13 and July 1, 2022. A copy of the Order of Protection is filed with this Motion as **Exhibit 1**.

This Motion does not seek reversal of the Court's Conclusions of Law as stated in the Court's June 28, 2022 email to counsel.

FINDINGS OF FACT TO BE ALTERED OR AMENDED

Plaintiff respectfully moves the Court to amend its Order eliminating or substantially modifying following Findings of Fact, which are unnecessary and are inconsistent with the facts alleged in the Complaint:

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Paragraph #	Alteration or Modification Needed	Basis
7	Remove “at Client’s request”	Not alleged in Complaint and not needed to support Court’s Conclusions of Law.
10-13	Remove entire paragraph.	Not alleged in Complaint and not needed to support Court’s Conclusions of Law.
14	Revise paragraph to state, “On March 2, 2019, D&M sent a revised letter of protection to Plaintiff ‘wherein the Lawyers agreed “to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above.’”	To conform with the text of the email attached as an Exhibit to the Complaint.
16-24	Remove entire paragraph.	Not alleged in Complaint and not needed to support Court’s Conclusions of Law.
41	Revise paragraph to remove the portion stating, “to establish it had a right to rely on the truth of any representation made to it in connection with this matter.” To be replaced with language consistent with the Court’s June 9, 2022, email, finding Plaintiff “has not alleged facts sufficient to state a cause of action for (1) Breach of Contract Accompanied by a Fraudulent Act, (2) Fraud, (3) Constructive Fraud, or (4) Unjust Enrichment[.]”	Not alleged in Complaint and needs revisions to accurately support Court’s Conclusions of Law.
45	Remove entire paragraph.	Not alleged in Complaint and not needed to support Court’s Conclusions of Law.
48	Remove entire paragraph.	Not alleged in Complaint and not needed to support Court’s Conclusions of Law.
50-62	Remove entire paragraph.	Not alleged in Complaint and not needed to support Court’s Conclusions of Law.
68	Remove entire paragraph.	Not alleged in Complaint and not needed to support Court’s Conclusions of Law.
75	Remove entire paragraph.	Not alleged in Complaint and not needed to support Court’s Conclusions of Law.

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CONCLUSION

Because the Court found the Verified Complaint alleges facts supporting causes of action for Breach of Contract and for the Defendants' alleged violations of the South Carolina Unfair Trade Practices Act, the factual findings identified above should be altered, amended, or revised to allow Plaintiff to litigate its remaining claims without being hindered by the findings of fact construed by Defendant in the Order presented to the Court before the undersigned had an opportunity to review and comment.

Respectfully submitted,

s/ Thomas A. Pendarvis
Thomas A. Pendarvis (SC Bar #64918)
Christopher W. Lempesis, Jr. (SC Bar #77012)
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Counsel for Plaintiffs

Beaufort, South Carolina

July 5, 2022

EXHIBIT 1

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	
In Re:	)	
	)	
Thomas A. Pendarvis, Esquire	)	**CONSENT ORDER OF PROTECTION**
S.C. Bar No. 64918	)	
	)	
	)	
	)	

It appearing to the Court that Thomas A. Pendarvis, Esquire (S.C. Bar No. 64918) has requested protection from appearance in the Ninth Judicial Circuit of Commons Pleas pending cases listed in "**Exhibit 1**" attached hereto, for the period of **June 13, 2022 through and including July 1, 2022**, for a planned vacation. It appearing that this is a reasonable request, and on consent of all counsel.

THEREFORE, it is ordered that Thomas A. Pendarvis, Esquire be protected from court appearances and trial in the pending cases listed in "**Exhibit 1**" attached hereto, from **June 20, 2022 through and including July 1, 2022**.

The Honorable Jennifer B. McCoy
Chief Administrative Judge
Ninth Judicial Circuit

Dated: _____, 2022

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ELECTRONICALLY FILED - 2022 Apr 25 5:32 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

EXHIBIT 1

Arthur H. Applegate and APPLEGATE & CO. v. J. Rutledge Young, Jr., Esq. and DUFFY & YOUNG, LLC
C.A. No. 2019-CP-10-02142

CAROLINA NEUROSURGERY & ORTHOPEDICS, INC. v. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP
C.A. No. 2021-CP-10-03379

COBB, DILL & HAMMETT, LLC v. Chris Khamnei and COLUMBUS STREET HOLDINGS, LLC
C.A. No. 2018-CP-10-01622

Chris C. Khamnei v. COBB, DILL & HAMMETT
C.A. No. 2021-CP-10-05593

Madalyn Schlegel Lasine v. John R. Kuhn, Esq. and KUHN & KUHN, LLC
C.A. No. 2021-CP-10-03105

John Doe, Jane Doe Mother and John Doe Father v. CLAWSON FARGNOLI, LLC.; Samuel R. Clawson, Jr., Esq.; Christina R. Fargnoli, Esq.; Barret R. Brewer, Esq.; and BREWER LAW FIRM, LLC
C.A. No. 2021-CP-10-01343

David Peters Wilborn, Jr. v. Amy Skipper and Lynn Benasutti
C.A. No. 2021-CP-10-01503

Warren R. Lokey v. Michael J. Zinn and David Zinn, M.D. and EASTSIDE LIVING, LLC, Nominal Defendant EASTSIDE LIVING, LLC, Michael J. Zinn and David Zinn, M.D. v. THE LOKEY LAW FIRM, LLC
C.A. No. 2021-CP-10-02945

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Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Protection from Court Appearance

So Ordered

s/Julie J. Armstrong, Charleston County Clerk of Court

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	IN THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopaedics, Inc.,	)	
	)	**ANSWER OF DEFENDANTS MICHAEL A. MAUCHER, ESQ. AND DELUCA & MAUCHER, LLP**
Plaintiff,	)	
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	
	)	

COME NOW Defendants Michael A. Maucher, Esq. ("Maucher") and Deluca & Maucher, LLP ("D&M") (collectively, "Defendants"), by and through their undersigned counsel, and hereby respond to Plaintiff's Complaint filed herein.[1] Defendants would respectfully show this Court as follows:

PLAINTIFF'S SUMMARY OF THE CASE

1. Defendants deny Paragraph 1 of the Complaint as stated.

PARTIES

2. In response to Paragraph 2, Defendants deny that Plaintiff is a citizen and resident of Charleston County, South Carolina and is licensed to practice medicine in South Carolina. Upon information and belief, Defendants admit that Jason M. Highsmith, M.D. is Plaintiff's primary surgeon. Defendants deny any remaining allegations of Paragraph 2.

3. Defendants admit Paragraph 3 of the Complaint.

[1] Plaintiff's claims for Breach of Contract Accompanied by a Fraudulent Act, Fraud, Constructive Fraud, Unjust Enrichment, and Negligence have been dismissed with prejudice pursuant to Court order. This Answer responds to Plaintiff's remaining allegations.

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4. In response to Paragraph 4, Defendants admit only that D&M operates as a law practice and has one office in Charleston County, South Carolina. Defendants deny the remaining allegations of Paragraph 4 as stated.

JURISDICTION

5. In response to Paragraph 5, Defendants admit only that this Court has jurisdiction and deny any remaining allegations inconsistent herewith.

VENUE

6. In response to Paragraph 6, Defendants admit only that venue is proper in Charleston County because Maucher resides in Charleston County, and the acts and omissions complained of occurred in Charleston County. Defendants deny the remaining allegations of Paragraph 6.

PLAINTIFF'S FACTS

7. Defendants admit Paragraph 7 of the Complaint.

8. Defendants lack sufficient information to admit or deny Paragraph 8 of the Complaint.

9. Defendants deny Paragraph 9 of the Complaint.

10. Defendants deny Paragraph 10 of the Complaint.

11. In response to Paragraph 11, Defendants admit only that on December 20, 2018, Defendants sent a letter of protection in which D&M agreed to "protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above." Defendants further admit that said December 20, 2018 letter of protection is attached to Plaintiff's Complaint as Exhibit 1. Defendants deny the remaining allegations of Paragraph 11 as stated.

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12. In response to Paragraph 12, Defendants admit only that Plaintiff's Financial Policy is attached to Plaintiff's Complaint as Exhibit 2. Defendants crave reference to said Financial Policy and deny any allegations in Paragraph 12 inconsistent therewith. Defendants deny the remaining allegations of Paragraph 12.

13. Defendants lack sufficient information to admit or deny Paragraph 13 of the Complaint.

14. In response to Paragraph 14, Defendants admit only that they knew Plaintiff was offering to provide medical/surgical services to Defendants' client. Defendants deny that Defendants knew Plaintiff and Dr. Highsmith were "out of network" healthcare providers for Defendants' client. Defendants lack sufficient information to admit or deny the remaining allegations of Paragraph 14.

15. Defendants deny Paragraphs 15 of the Complaint.

16. Defendants deny Paragraph 16 of the Complaint.

17. In response to Paragraph 17, Defendants admit upon information and belief only that in January 2019, Plaintiff and Dr. Highsmith started providing Defendants' client's treatments. Defendants further admit upon information and belief that a Statement dated November 2, 2020 is attached to Plaintiff's Complaint as Exhibit 3. Defendants lack sufficient information to admit or deny the remaining allegations of Paragraph 17.

18. In response to Paragraph 18, Defendants admit only that an email thread, dated January 16-21, 2019 is attached to Plaintiff's Complaint as Exhibit 4. Defendants deny the remaining allegations of Paragraph 18 as stated.

19. Defendants deny Paragraph 19 of the Complaint as stated.

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20. In response to Paragraph 20, Defendants admit only that on January 21, 2019, at 11:58:35 a.m., they sent a second email discussing pre-existing injuries to Plaintiff, and that said email is attached to Plaintiff's Complaint as Exhibit 5. Defendants further crave reference to said email and deny any remaining allegations in Paragraph 20 inconsistent therewith.

21. Defendants deny Paragraph 21 of the Complaint as stated.

22. Defendants admit Paragraph 22 of the Complaint.

23. Defendants admit Paragraph 23 of the Complaint.

24. In response to Paragraph 24, Defendants crave reference to the text of the March 7, 2019 Letter of Protection, attached to Plaintiff's Complaint as Exhibit 6, and deny any allegations in Paragraph 24 inconsistent therewith.

25. Defendants deny Paragraph 25 of the Complaint as stated.

26. In response to Paragraph 26, Defendants admit on information and belief only that on March 15, 2019, Dr. Highsmith performed surgery on Defendants' client. Defendants lack sufficient information to admit or deny the remaining allegations of Paragraph 26.

27. Defendants admit Paragraph 27 of the Complaint.

28. In response to Paragraph 28, Defendants admit only that a "Health Insurance Verification Form," dated April 26, 2019 and purportedly signed by Defendants' client, is attached to Plaintiff's Complaint as Exhibit 8. Defendants lack sufficient information to admit or deny the remaining allegations of Paragraph 28.

29. Defendants admit Paragraph 29 of the Complaint.

30. In response to Paragraph 30, Defendants admit only that an April 30, 2019 email from Plaintiff to Defendants is attached to Plaintiff's Complaint as Exhibit 10. Defendants lack sufficient information to admit or deny the remaining allegations of Paragraph 30.

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31. In response to Paragraph 31, Defendants admit on information and belief only that on May 2, 2019, Dr. Highsmith performed additional surgery on Defendants' client. Upon information and belief, Defendants deny the approximate cost of said surgery was $65,000. Defendants lack sufficient information to admit or deny the remaining allegations of Paragraph 31.

32. Defendants admit Paragraph 32 of the Complaint.

33. In response to Paragraph 33, Defendants crave reference to the November 2, 2020 Statement attached to Plaintiff's Complaint as Exhibit 3 and deny any allegations in Paragraph 33 inconsistent therewith.

34. Defendants admit Paragraph 34 of the Complaint.

35. In response to Paragraph 35, Defendants admit only that the total recovery for Defendants' client from liability insurance coverage was only $30,000. Defendants deny the remaining allegations of Paragraph 35.

36. Defendants lack sufficient information to admit or deny Paragraph 36 of the Complaint.

37. Defendants deny Paragraph 37 of the Complaint as stated.

38. In response to Paragraph 38, Defendants admit only that Defendants do maintain and have maintained that Plaintiff should have submitted its invoices to the health insurance carrier for Defendants' client. Defendants deny the remaining allegations of Paragraph 38.

39. Defendants deny Paragraph 39 of the Complaint.

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PLAINTIFF'S FIRST CAUSE OF ACTION
(Breach of Contract)

40. In response to Paragraph 40, Defendants incorporate and reassert the foregoing responses as if more fully set forth verbatim herein.

41. Defendants deny Paragraph 41 of the Complaint.

42. Defendants deny Paragraph 42 of the Complaint.

43. Defendants deny Paragraph 43 of the Complaint.

44. Defendants deny Paragraph 44 of the Complaint.

45. Defendants deny Paragraph 45 of the Complaint.

37. Defendants deny Paragraph 37[2] of the Complaint.

PLAINTIFF'S SECOND CAUSE OF ACTION
(Breach of Contract Accompanied by a Fraudulent Act)

38. In response to Paragraph 38, Defendants incorporate and reassert the foregoing responses as if set forth herein.

39. Plaintiff's second cause of action was dismissed with prejudice by Court order and, accordingly, no response is required to Paragraph 39. To the extent one is deemed required, Defendants deny the allegations.

40. Plaintiff's second cause of action was dismissed with prejudice by Court order and, accordingly, no response is required to Paragraph 40. To the extent one is deemed required, Defendants deny the allegations.

[2] At this point in Plaintiff's Complaint the paragraph numbering restarts at 37. Defendants' answer is similarly numbered to avoid any confusion related to which paragraphs the Defendants are responding.

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41. Plaintiff's second cause of action was dismissed with prejudice by Court order and, accordingly, no response is required to Paragraph 341. To the extent one is deemed required, Defendants deny the allegations.

42. Plaintiff's second cause of action was dismissed with prejudice by Court order and, accordingly, no response is required to Paragraph 42. To the extent one is deemed required, Defendants deny the allegations.

43. Plaintiff's second cause of action was dismissed with prejudice by Court order and, accordingly, no response is required to Paragraph 43. To the extent one is deemed required, Defendants deny the allegations.

44. Plaintiff's second cause of action was dismissed with prejudice by Court order and, accordingly, no response is required to Paragraph 44. To the extent one is deemed required, Defendants deny the allegations.

45. Plaintiff's second cause of action was dismissed with prejudice by Court order and, accordingly, no response is required to Paragraph 45. To the extent one is deemed required, Defendants deny the allegations.

46. Plaintiff's second cause of action was dismissed with prejudice by Court order and, accordingly, no response is required to Paragraph 46. To the extent one is deemed required, Defendants deny the allegations.

PLAINTIFF'S THIRD CAUSE OF ACTION
(Violation of South Carolina Unfair Trade Practices Act)

47. In response to Paragraph 47, Defendants incorporate and reassert the foregoing responses as if set forth herein.

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48. Defendants are informed and believe that Paragraph 48 of the Complaint does not require a response.

49. In response to Paragraph 49, Defendants admit only that they engaged in trade and commerce in practicing law in the course and scope of their representation of Defendants' client. Defendants deny the remaining allegations of Paragraph 49.

50. Defendants deny Paragraph 50 of the Complaint.

51. Defendants deny Paragraph 51 of the Complaint.

52. Defendants deny Plaintiff's entitlement to any of the damages and any other relief sought in the Paragraph beginning with "WHEREFORE," which immediately follows Paragraph 51.

53. Plaintiff's causes of action for Fraud, Constructive Fraud, Unjust Enrichment, and Negligence, detailed in Paragraphs 46-80 in the Complaint, were dismissed with prejudice by Court order and, accordingly, no response is required from Defendants. To the extent a response is deemed required, Defendants deny all allegations contained within those causes of action.

54. Defendants deny any and all relief sought by Plaintiff in its Prayer for Relief.

55. Defendants deny each and every allegations contained in the Complaint that was not specifically admitted.

FIRST AFFIRMATIVE DEFENSE
(Failure to Mitigate Damages)

Plaintiff may have failed to mitigate its damages, if any, as required under South Carolina law.

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SECOND AFFIRMATIVE DEFENSE
(Lack of Mutual Assent)

Plaintiff and Defendants may not have agreed to all essential and material terms relating to the matters underlying the March 7, 2019 Letter of Protection.

THIRD AFFIRMATIVE DEFENSE
(No Acceptance by Plaintiff)

To the extent the March 7, 2019 Letter of Protection constitutes an offer by D&M inviting acceptance by Plaintiff in a certain manner, Plaintiff failed to comply with the prescribed manner of acceptance. Therefore, no valid contract between the parties was formed.

FOURTH AFFIRMATIVE DEFENSE
(Failure of Conditions Precedent)

In the event the Court finds the March 7, 2019 Letter of Protection constitutes a valid contract, Plaintiff has failed to satisfy all necessary conditions precedent to D&M's performance thereunder because Plaintiff failed to file any claims for payment of its services rendered with Defendants' clients' private health insurance, prior to seeking payment from Defendants.

FIFTH AFFIRMATIVE DEFENSE
(Abandonment)

To the extent the December 20, 2018 Letter of Protection constitutes an offer and/or contract between D&M and Plaintiff—which Defendants expressly deny—Plaintiff acquiesced in and agreed to Defendants' abandonment thereof.

SIXTH AFFIRMATIVE DEFENSE
(Waiver, Estoppel, and Laches)

Plaintiff's claims are or may be barred by the doctrines of waiver, estoppel and/or laches.

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SEVENTH AFFIRMATIVE DEFENSE
(No Causation)

Any damages alleged to have been suffered by Plaintiff were not the direct and proximate result of any alleged breaches of contract by Defendants.

EIGHTH AFFIRMATIVE DEFENSE
(Limitation of Damages)

In the event the Court finds that either Letter of Protection constitutes a valid contract between Plaintiff and that D&M has breached the contract, Plaintiff may not recover consequential damages or any other items of special damages, pursuant to Rule 9(g), SCRCP and South Carolina common law.

NINTH AFFIRMATIVE DEFENSE
(Controlling Person)

In the event the Court finds D&M violated the South Carolina Unfair Trade Practices Act—which Defendants expressly deny—as a named partner of D&M, Maucher may not be subject to personal liability for any such violations by D&M, pursuant to South Carolina law, including the controlling person doctrine.

TENTH AFFIRMATIVE DEFENSE
(No Adverse Effect on Public Interest)

Defendants' alleged conduct complained of in Plaintiff's Complaint did not adversely affect the public interest and does not have the potential for repetition. Therefore, Plaintiff cannot maintain a claim against Defendants for violation of the South Carolina Unfair Trade Practices Act.

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ELEVENTH AFFIRMATIVE DEFENSE
(Lack of Willfulness)

In the event the Court finds Defendants' alleged conduct complained of in Plaintiff's Complaint violates the South Carolina Unfair Trade Practices Act, any such conduct does not constitute a willful or knowing violation of the Unfair Trade Practices Act. Accordingly, Plaintiff may not recover treble damages.

TWELFTH AFFIRMATIVE DEFENSE
(Frivolous Proceedings)

That Plaintiff and its counsel have filed and prosecuted frivolous claims against Defendants and should be sanctioned under section 15-36-10 of the South Carolina Code.

THIRTEENTH AFFIRMATIVE DEFENSE
(General Reservation)

Defendants reserve any additional and further defenses as may be revealed by additional information during the course of discovery and investigation, and as are consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully responded to Plaintiff's Complaint, Defendants respectfully request that this Court inquire as to the matters raised herein, that Plaintiff's claims be dismissed with costs taxed against Plaintiff, and for such other and further relief as the Court deems just and proper.

This 6th day of April, 2023.

Respectfully submitted,

COPELAND, STAIR, VALZ & LOVELL, LLP

By: *s/ Skyler C. Wilson*
DOUGLAS W. MACKELCAN
State Bar No.: 76332
SKYLER C. WILSON
State Bar No.: 102865
Attorneys for Defendants

40 Calhoun Street, Suite 400
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Ph: 843-727-0307

ELECTRONICALLY FILED - 2023 Apr 06 10:13 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

ELECTRONICALLY FILED - 2023 Aug 22 11:12 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON Carolina Neurosurgery & Orthopaedics, Inc., Plaintiff, vs. Michael A. Maucher, Esq. and DeLuca & Maucher, LLP, Defendants.	IN THE COURT OF COMMON PLEAS IN THE NINTH UDICIAL CIRCUIT CASE NO.: 2021-CP-10-03379 **DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

TO: THOMAS A. PENDARVIS, ESQUIRE, ATTORNEY FOR PLAINTIFF:

Defendants Michael A. Maucher, Esq. and Deluca & Maucher, LLP, by and through their undersigned counsel, will move before this Honorable Court on the tenth day after service hereof, or as soon thereafter as counsel may be heard, for an order granting summary judgment in favor of Defendants as to all claims asserted herein by Plaintiff and dismissing such claims with prejudice, pursuant to Rule 56, SCRCP.

Plaintiff sued Defendants for Breach of Contract, Fraud, Constructive Fraud, Breach of Contract Accompanied by a Fraudulent Act, Unjust Enrichment, Negligence, and violation of the South Carolina Unfair Trade Practice Act. Defendants moved to dismiss the claims and the Court dismissed all of Plaintiff's claims except for Breach of Contract and violation of SCUTPA. Defendants are entitled to summary judgment on Plaintiff's remaining claims because there is no genuine issue of material fact on one or more of the elements of Breach of Contract or violation of SCUTPA. Specifically, Defendants did not breach any contract or agreement with Plaintiff. Further, Defendants' actions were not unfair or deceptive, did not affect the public interest, and

Plaintiff has not suffered an ascertainable loss of money or property as a result of an unfair or deceptive act.

Defendants respectfully request this Court to enter an Order granting their Motion, dismissing Plaintiff's claims for Breach of Contract and violation of SCUTPA, and ordering any additional relief the court deems just and proper. This Motion will be supplemented by a memorandum of supporting law and evidence in advance of a hearing on the Motion.

This 22nd day of August, 2023.

Respectfully submitted,

COPELAND, STAIR, VALZ & LOVELL, LLP

By: *s/Douglas W. MacKelcan*
DOUGLAS W. MACKELCAN
State Bar No.: 76332
SKYLER C. WILSON
State Bar No.: 102865
Attorneys for Defendants

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Charleston, SC 29401-3531
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Ph: 843-727-0307

ELECTRONICALLY FILED - 2023 Aug 22 11:12 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

ELECTRONICALLY FILED - 2023 Sep 06 10:48 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP Defendants.	**PLAINTIFF'S MOTION TO AMEND COMPLAINT**

TO: DOUGLAS W. MACKELCAN, ESQ. AND SKYLER C. WILSON, ESQ., COUNSEL FOR DEFENDANTS:

NOTICE

YOU WILL PLEASE TAKE NOTICE THAT on the 10th day after service hereof, or as soon thereafter as counsel can be heard before the presiding judge for the Court of Common Pleas for Charleston County, in the Charleston County Courthouse or at such other time and place as is convenient to the Court and counsel, Plaintiff, Carolina Neurosurgery & Orthopedics, Inc., will move pursuant to Rule 15, SCRCP, for an order allowing Plaintiff to amend its Complaint.

MOTION

Pursuant to Rule 15, SCRCP, Plaintiff, Carolina Neurosurgery & Orthopedics, Inc., moves this Court for an Order allowing Plaintiff to amend its Complaint to assert additional legal theories arising out of the facts alleged in the original Verified Complaint. A copy of the proposed Amended Complaint is filed with this motion as **Exhibit 1**.

LAW, ARGUMENT, AND ANALYSIS

I. Justice requires leave for Plaintiff to amend its pleadings because there will be no prejudice to Defendants by allowing amendments adding legal theories premised on facts known to Defendants and already implicated in Plaintiff's original Verified Complaint.

Amendment of pleadings is controlled by Rule 15, SCRCP. The Rule provides in pertinent

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part:

> A party may amend his pleading once as a matter of course at any time before . . . a responsive pleading is served or, . . . he may so amend it at any time within 30 days after it is served. Otherwise a party may amend his pleading only by leave of court or by written consent of the adverse party; and leave shall be freely given when justice so requires and does not prejudice any other party.

Rule 15(a), SCRCP.

A motion to amend is addressed to the sound discretion of the trial judge discretion, and the party opposing the motion has the burden of establishing prejudice. See Shah v. Richland Mem'l Hosp., 350 S.C. 139, 147-48, 564 S.E.2d 681, 685-86 (Ct. App. 2002) (holding the trial court erred in denying the appellant's motion to amend the complaint stating "[t]he test of whether an amendment should be allowed is whether the amendment will prejudice or work an injustice to the adverse party" (quoting Forrester v. Smith & Steele Builders, Inc., 295 S.C. 504, 509, 369 S.E.2d 156, 159 (Ct. App. 1988))). Prejudice occurs when the amendment states a new claim or defense that would require the opposing party to introduce additional or different evidence to prevail in the amended action. Holland ex rel. Knox v. Morbark, Inc., 407 S.C. 227, 235, 754 S.E.2d 714, 719 (Ct. App. 2014). Leave to amend pleadings pursuant to Rule 15 shall be liberally and freely given when justice so requires and does not prejudice any other party in so far as the party opposing the amendment are able to establish that the proposed amendments would cause a lack of notice that the new issue is going to be tried, and a lack of opportunity to refute it. Parker v. Spartanburg Sanitary Sewer Dist., 362 S.C. 276, 286, 607 S.E.2d 711, 716-17 (Ct. App. 2005). The South Carolina Court of Appeals has indicated that the "rule strongly favors amendments and the court is encouraged to freely grant leave to amend." Jarrell v. Seaboard Systems RR, Inc., 294 S.C. 183, 186, 363 S.E.2d 398, 399 (Ct. App. 1987).

Further, the Supreme Court that a trial court's "decision to deny a motion to amend should

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not be based on the court's perception of the merits of an amended complaint." Skydive Myrtle Beach, Inc. v. Horry Cnty., 426 S.C. 175, 182, 826 S.E.2d 585, 589 (2019). The Court of Appeals ruled that "[i]n the absence of a proper reason, such as bad faith, undue delay or prejudice, a denial of leave to amend is an abuse of discretion. It is the responsibility of the party opposing an amendment to establish prejudice. See Harvey v. Strickland, 350 S.C. 303, 313, 566 S.E.2d 529, 535 (2002) ("A motion to amend is addressed to the sound discretion of the trial judge, and the party opposing the motion has the burden of establishing prejudice."); Forrester v. Smith & Steele Builders, 295 S.C. at 508, 369 S.E.2d at 158.

The status of this case establishes that Defendants will not be able to show prejudice from an amendment adding additional legal theories.

Finally, the proposed Amended Complaint is not being filed in bad faith, after undue delay, nor will it cause prejudice to Defendants.

WHEREFORE, Plaintiff, Carolina Neurosurgery & Orthopedics, Inc., respectfully requests this Court issue an Order granting its Motion to Amend its Complaint.

Respectfully submitted,

PENDARVIS LAW OFFICES, P.C.

s/ Thomas A. Pendarvis
Thomas A. Pendarvis (SC Bar #64918)
Christopher W. Lempesis, Jr. (SC Bar #77012)
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Counsel for Plaintiff

Beaufort, South Carolina

September 6, 2023

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EXHIBIT 1

ELECTRONICALLY FILED - 2023 Sep 06 10:48 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP Defendants.	**AMENDED SUMMONS**

TO: THE DEFENDANTS ABOVE NAMED:

YOU ARE HEREBY SUMMONED and required to answer the Amended Complaint, a copy of which is served upon you, and to serve a copy of your Answer to the Amended Complaint on the Plaintiff's attorney within (30) days after the service hereof, exclusive of the day of such service, and if you fail to answer the Verified Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Amended Complaint.

/s/ Thomas A. Pendarvis
Thomas A. Pendarvis (SC Bar #64918)
Christopher W. Lempesis, Jr. (SC Bar #77012)
PENDARVIS LAW OFFICES, P.C.
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Counsel for Plaintiff

Beaufort, South Carolina

September 4, 2023

ELECTRONICALLY FILED - 2023 Sep 06 10:48 AM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP Defendants.	**AMENDED COMPLAINT**[1] **(Jury Trial Demanded)** 1. Breach of Contract; 2. Violation SC Unfair Trade Practices Act 3. Negligent Misrepresentation; and 4. Promissory Estoppel.

Plaintiff, CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., complaining of Defendants, Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, respectfully shows unto the Court:

SUMMARY OF THE CASE

1. This case arises from Defendants' false and inaccurate representations about the availability of $1,000,000 in insurance coverage they were pursuing to cover medical and surgical expenses for one of Defendants' clients that induced Plaintiff to perform over $125,000 in surgery and related healthcare services for Defendants' client when, contrary to Defendants' representations, there was no available insurance coverage or the Defendants were unable to recover insurance proceeds to pay for the surgeries.

PARTIES

2. Plaintiff, CAROLINA NEUROSURGERY & ORTHOPEDICS, INC. ("Carolina Neurosurgery"), is a Corporation organized and existing under the laws of South Carolina with offices in Charleston County, South Carolina.

3. Defendant, Michael A. Maucher, Esq. ("Mr. Maucher"), is, upon information and belief, a citizen and resident of Charleston County, South Carolina.

[1] Plaintiff respectfully reserves its objections and potential appeal of the trial court's ruling granting Defendants' motion to dismiss Plaintiff's claims asserted in the original Complaint for Breach of Contract Accompanied by a Fraudulent Act, Fraud, Constructive Fraud, and Unjust Enrichment.

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4. Defendant, DELUCA & MAUCHER, LLP ("the Law Firm"), is, upon information and belief, a South Carolina Limited Liability Partnership operating as a law practice with offices in Charleston County, South Carolina. (Mr. Maucher and the Law Firm will be referred to collectively as "the Lawyers".)

JURISDICTION

5. This Court has jurisdiction based upon Article V of the South Carolina Constitution, S.C. CODE ANN. §§ 36-2-802 and 36-2-803, and its plenary powers.

VENUE

6. Venue is proper in Charleston County because, upon information and belief, Mr. Maucher resides in Charleston County, the Lawyers' offices are in Charleston County, and the acts and omissions complained of occurred in Charleston County, South Carolina.

FACTS

7. In December 2018, an individual identified in this Amended Complaint as "the Lawyers' client" was injured in a motor vehicle collision. The Lawyers' client was a prior patient of Carolina Neurosurgery's surgeon, Dr. Highsmith, and had a procedure with Dr. Highsmith before December 2018.

8. On December 20, 2018, the Lawyers sent Carolina Neurosurgery a "Letter of Protection" ("the LOP") promising to "protect *any claim* which you may have out of any settlement proceeds we may receive arising of the incident referred to above" to secure payment for all future surgeries and medical treatment expenses out of liability insurance proceeds providing coverage for the Lawyers' client's claims.

9. Based on the Lawyers' representations, Carolina Neurosurgery began treating the Lawyers' client's collision-related injuries providing elective treatments for the benefit of the Lawyers' client under Carolina Neurosurgery's "Financial Policy."

10. At the time of the Lawyers' representations and thereafter, all involved parties including the Lawyers' client, the Lawyers, and Carolina Neurosurgery, knew or should have known a) Carolina Neurosurgery and its' surgeon, Dr. Highsmith were "out-of-network" healthcare providers for the Lawyers' client and b) Carolina Neurosurgery was offering to provide elective medical/surgical services for the Lawyers' client.

11. Because the Lawyers' client did not have in-network health insurance coverage for any treatments provided by Carolina Neurosurgery, payment for services fell under the second

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bullet point of Carolina Neurosurgery's "Financial Policy", "IF YOU DO NOT HAVE INSURANCE:"

> *Our policy requires payment in full today, unless, other arrangements are made. If you cannot pay in full now, we request partial payment today as you arranged for credit on your account with a payment plan agreement with our credit and collection manager.*

12. At this time, based on the Lawyers' representations, the "*other arrangements*" would be provided by various liability insurance policies over $1,000,000 that the Lawyers represented were available to cover medical expenses related to the Lawyers' client's personal injury claims.

13. On January 21, 2019 at 9:24 am, the Lawyers provided Carolina Neurosurgery written confirmation of the limits of coverage that would fund additional expenses for elective treatment to be provided to the Lawyers' client, stating, "[*the Lawyer's client] carries $100,000.00 in Underinsured Motorist Coverage on his at-home policy with Safeco, and there is $1,000,000.00 in 'Occupational Accident Coverage' to pay bills and wages under the One Beacon Policy*.

14. On January 21, 2019, at 11:58:35 AM, the Lawyers sent a second email discussing pre-existing injuries and indicating that they preferred that treatment not be provided under the LOP but did not explain or disclose that their prior statements representing there was $1,000,000 in insurance coverage were incorrect.

15. On March 7, 2019, the Lawyers forwarded a second Letter of Protection by email wherein the Lawyers agreed "to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above" but again did not inform or disclose to Carolina Neurosurgery that their prior representation of the availability of over $1,000,000 in liability insurance policies providing coverage was not correct.

16. On March 15, 2019, Carolina Neurosurgery relying on the Lawyers' representations of insurance coverage performed surgery on the Lawyers' client at an approximate cost of $60,000.

17. On April 29, 2019, at 11:20 am, the Lawyers sent Carolina Neurosurgery an email stating, "*Because the at-fault party only had $30,000.00, and [the Lawyers' client]'s Underinsured Motorist Coverage does not apply, ALL of the treatment [the Lawyers' client] has received (and will continue to receive) must be filed under his private health insurance. We cannot honor anymore treatment under a Letter of Protection. Please note [the Lawyers' client]'s file accordingly*."

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18. The Lawyers' April 29, 2019, 11:20 am email, however, did not advise or explain that there was no coverage under the "*$1,000,000.00 in 'Occupational Accident Coverage' ... under the One Beacon Policy"* as stated in the Lawyers' January 21, 2019 at 9:24 am email.

19. On May 2, 2019, relying on the Lawyers' promises and assurances on the amount of insurance coverage, Carolina Neurosurgery performed a second surgery on the Lawyers' client at an approximate cost of $65,000.

20. The Lawyers did not explain or disclose to Carolina Neurosurgery that the Lawyers' prior statements representing there was over $1,000,000 in insurance coverage were not correct until after Carolina Neurosurgery provided treatments and performed two surgeries to the Lawyers' client.

21. The final invoice for the additional elective treatments Carolina Neurosurgery provided the Lawyers' client through December 20, 2019, is $125,409.25.

22. Upon information and belief, the Lawyers were not able to collect any of the "*$1,000,000.00 in 'Occupational Accident Coverage' ... under the One Beacon Policy"* to pay for the two surgeries Carolina Neurosurgery provided based on the Lawyers' representations.

23. Neither the Lawyers nor the Lawyers' client have paid Carolina Neurosurgery the outstanding balance of $125,409.25.

24. The Lawyers' representations to Carolina Neurosurgery there was "*$1,000,000.00 in 'Occupational Accident Coverage' ... under the One Beacon Policy"* were either not true or the Lawyers were not able to secure payment from One Beacon on the subject policy.

25. Carolina Neurosurgery would not have performed the two surgeries on the Lawyers' client but for the representations made by the Lawyers concerning the insurance coverage.

FOR A FIRST CAUSE OF ACTION
(Breach of Contract)

26. Carolina Neurosurgery realleges and incorporates the foregoing factual and jurisdictional statements by reference as if they were set forth herein.

27. Carolina Neurosurgery and the Lawyers entered into a contract wherein Carolina Neurosurgery would provide medical services to the Lawyers' client based on the Lawyers' representations about insurance coverage.

28. Carolina Neurosurgery fulfilled all necessary preconditions, if any, of the contract.

29. The Lawyers breached the contract.

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30. As a direct and proximate cause of the Lawyers' multiple or singular breach of the contract, Carolina Neurosurgery sustained actual, consequential, and incidental damages in an amount to be determined by the jury at the trial of this case.

31. Under the Contract, Carolina Neurosurgery also requests all fees and costs generated in pursue of the relief claimed, including but not limited to legal fees.

37. WHEREFORE, Carolina Neurosurgery demands judgment and an award against the Lawyers under this breach of contract cause of action for actual damages, consequential damages, pre-judgment interest, court costs; and such other and further relief the Court deems just and proper.

FOR A SECOND CAUSE OF ACTION
(Violation of The South Carolina Unfair Trade Practices Act)

38. The foregoing factual and jurisdictional allegations are reiterated and realleged as though set forth verbatim.

39. This is a cause of action under the South Carolina Unfair Trade Practice Act, S.C. CODE ANN. §39-5-10, et seq.

40. The Lawyers engaged in trade or commerce in South Carolina, including practicing law in representing the Lawyers' Client, who, as alleged throughout this Complaint, have engaged in unfair or deceptive acts or practices of trade or commerce. Further, the Lawyers' use of such unfair and/or deceptive acts was willful.

41. The Lawyers' conduct is capable of repetition.

42. As a direct and proximate result of the Lawyers' use or employment of unfair and/or deceptive acts of trade or commerce as described in this Complaint, Carolina Neurosurgery has suffered an ascertainable loss of money or property.

WHEREFORE, Carolina Neurosurgery is entitled to and requests an award of actual damages under this Unfair Trade Practices Act claim for actual damages, consequential damages, pre-judgment interest, court costs; and such other and further relief the Court deems just and proper. Further Carolina Neurosurgery is entitled to and requests an award of treble damages, legal fees, and costs, for the Lawyers' willful conduct and statutory violation.

FOR A THIRD CAUSE OF ACTION
(Negligent Misrepresentation)

32. Carolina Neurosurgery realleges and incorporates the foregoing factual and

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jurisdictional statements by reference as if they were set forth herein.

33. The Lawyers made false representations to Carolina Neurosurgery.

34. The Lawyers had a pecuniary interest in making the statements to Carolina Neurosurgery.

35. The Lawyers owed a duty of care to see that they communicated truthful information to Carolina Neurosurgery, including duties grounded in the Lawyers' obligations under Rule 4.1(a), RPC, Rule 407, SCACR - Truthfulness in Statements to Others and other Rules and standards governing lawyers practicing law in South Carolina.

36. The Lawyers breached their duty duties to communicate truthful information to Carolina Neurosurgery by failing to exercise due care.

37. Carolina Neurosurgery justifiably relied on the Lawyer's representations.

38. Carolina Neurosurgery suffered a pecuniary loss as the proximate result of its reliance upon the Lawyers' representations.

39. WHEREFORE, Carolina Neurosurgery is entitled to and requests an award of actual damages against the Lawyers under this negligent misrepresentation claim for actual damages, consequential damages, pre-judgment interest, court costs; and such other and further relief the Court deems just and proper.

FOR A FOURTH CAUSE OF ACTION
(Promissory Estoppel)

40. Carolina Neurosurgery realleges and incorporates the foregoing factual and jurisdictional statements by reference as if they were set forth herein.

41. The Lawyers made unambiguous promise and gave unambiguous assurances to Carolina Neurosurgery concerning the availability of over $1 million in insurance coverage for the medical services Carolina Neurosurgery was to provide to the Lawyers' client.

42. Carolina Neurosurgery reasonably relied on the promise by the Lawyers.

43. Carolina Neurosurgery's reliance was expected by and foreseeable to the Lawyers.

44. Carolina Neurosurgery suffered substantial financial losses caused by its reasonable reliance on the Lawyers' unambiguous promises and unambiguous assurances concerning insurance coverage.

45. WHEREFORE, Carolina Neurosurgery is entitled to and requests an award of actual damages against the Lawyers under this promissory estoppel claim for actual damages, consequential damages, pre-judgment interest, court costs; and such other and further relief the

Court deems just and proper.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., prays for judgment against Defendants, Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, jointly and severally, for the relief sought in each of the Causes of Action asserted in this Verified Complaint, and for such other and further relief as this Court deems just and proper.

Respectfully submitted,

/s/ Thomas A. Pendarvis
Thomas A. Pendarvis (SC Bar #64918)
Christopher W. Lempesis, Jr. (SC Bar #77012)
PENDARVIS LAW OFFICES, P.C.
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Counsel for Plaintiff

Beaufort, South Carolina

September 4, 2023

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	
	)	
	)	PROOF OF ADR
Carolina Neurosurgery & Orthopaedics, Inc.	)	
Plaintiff,	)	
vs.	)	
	)	Docket No. 2021-CP-10-03379
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP	)	
Defendant.	)	

PURSUANT to the South Carolina Alternative Dispute Resolutions Rules (SCADR):

1. Alternative Dispute Resolution (ADR) was conducted on the 18th day of December 2023 in the form of
   a. ☒mediation
   b. ☐non-binding arbitration
   c. ☐binding arbitration (attached appropriate order of dismissal)

2. The neutral(s) was/were (Name(s) of arbitrator(s)/mediator(s))

   M. Dawes Cooke, Jr.

3. Present at the ADR conference were:
   a. ☒Plaintiff
   b. ☒Defendant
   c. ☒Lawyer(s) for Plaintiff Thomas Pendarvis
   d. ☒Lawyer(s) for Defendant Doug MacKelcan
   e. ☒Representative for Insurance CarrierAnne Foersch
   f. ☐Guardian *ad litem* _____
   g. ☐Expert(s) _____
   h. ☐Others _____

4. As a result of ADR, this case should be considered (check one)
   a. ☐fully settled by Consent Judgment to be filed by _____
   b. ☐fully settled Voluntary Dismissal to be filed by _____
   c. ☐Partially settled
   d. ☒at an impasse

Submitted this 2nd day of August, 2024

s/ M. Dawes Cooke, Jr. (SC Bar #1376)
Neutral's Signature/Electronic Signature

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	IN THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopaedics, Inc.,	)	
	)	**DEFENDANTS' MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**
Plaintiff,	)	
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	
	)	

Michael A. Maucher, Esq. and Deluca & Maucher, LLP, by and through their undersigned counsel, submit their Memorandum in Support of Summary Judgment, requesting this Court find there is no genuine issue of material fact and dismissing Plaintiff's remaining causes of action for (1) Breach of Contract and (2) violation of the South Carolina Unfair Trade Practice Act. Defendants reserve the right to supplement or amend this memorandum prior to a hearing on the motion.

INTRODUCTION

This case arises from Plaintiff's failure to exercise due diligence and follow its financial policy before proceeding with approximately $125,000.00 in surgical treatment for one of Defendants' clients (Client), who was injured in a motor vehicle collision on December 14, 2018. Defendants were unaware that Plaintiff and its surgeon, Dr. Highsmith, were "out of network" healthcare providers under Client's private health insurance.

Further, despite repeated instructions from both Defendants and Client regarding billing insurance for Plaintiff's services, Plaintiff never attempted to: (1) confirm with Defendants its network status with Client's health insurance; or (2) submit the proposed procedures to the

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Client's health insurance for pre-approval before proceeding with the surgeries. Until recently, however, Plaintiff had never attempted to submit claims for payment to the Client's health insurance following each of the surgeries. Moreover—despite Defendants' offer to pay Plaintiff out of the $30,000 settlement proceeds recovered for their client—Plaintiff not only rejected such offer, but it brought a debt collection action against Defendants' client in the Berkeley County, South Carolina Court of Common Pleas.[1] Plaintiff and Client resolved their case before trial, with Plaintiff accepting partial payment from Client's insurer for Client's medical bills Plaintiff asserts Defendants owe.

SUMMARY OF FACTS

Client was injured in a car accident on December 14, 2018. **Cmplt. ¶ 7**. Shortly thereafter, he retained Defendants to pursue claims against the at-fault driver. Before the accident, Client was a patient of Dr. Highsmith and Carolina Neurosurgery. **Cmplt. ¶ 7**. Client chose to return to Dr. Highsmith to treat the injuries he sustained in the car accident.

Defendants sent Plaintiff a letter of protection on December 20, 2018, that stated:

> Please accept this correspondence as our Law Firm's agreement to protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance.

Ex. A (First Letter of Protection).

On January 3, 2019, Client executed Plaintiff's Financial Policy. **Ex. B.** Under the section entitled "If you have insurance," the Financial Policy provides that Plaintiff "will file with [the patient's] primary insurance." **Ex. B.** The Financial Policy also provides that the

[1] *Carolina Neurosurgery and Orthodontics, Inc. v. Scott Demaskey*, 2021CP0801088.

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patient may be responsible for all of part of the balance not paid by the insurance company. **Ex. B**. At the time, Client had primary health insurance through Blue Cross/Blue Shield.

On January 21, 2019, Tina Bennett, a paralegal with Defendant Law Firm, responded to an inquiry from Kiara Goodwine, Plaintiff's employee, regarding the "limits" for Client, explaining the at-fault carrier was from North Carolina and would not disclose policy limits without a medical authorization, and they were unable to discover how much liability coverage the at-fault driver had. **Ex. C**. However, Bennett informed Goodwine that Client had $100,000 in UIM coverage on a Safeco Policy and carried $1,000,000 in "Occupational Accident Coverage" on a One Beacon policy. **Ex. C**.

Hours later the same day, Bennett emailed Goodwine and explained Client advised that he required surgery. **Ex. C**. Based on the seriousness of the injury, and pre-existing injuries, Bennett requested all of Client's treatment be filed with his private health insurance company. Further, that it "would be best for everyone involved if we NOT do the treatment under an Assignment/Letter of Protection." **Ex. C.** Goodwine responded, "Okay thanks for the update." **Ex. C**.

On March 7, 2019, Defendant Law Firm sent a revised Letter of Protection to Plaintiff, stating:

> Please accept this correspondence as our Law Firm's agreement to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance.

Ex. D (Second Letter of Protection). That same day, Client completed a Health Insurance Verification form for his upcoming surgery, providing Plaintiff with his BlueCross/BlueShield insurance information and the document was signed by Goodwine. **Ex. E.**

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Highsmith performed Client's first surgery on March 15, 2019 (First Surgery) and charged Client $58,697.41. For the First Surgery, Plaintiff did not submit any bills to BlueCross/BlueShield despite the language in the Letter of Protection and Client providing his insurance information.

As Client's personal injury case developed, it was determined that: (1) the at-fault driver did not have sufficient insurance coverage to fully cover Client's medical treatment; (2) one of Client's other additional policies was inapplicable; and (3) the other additional policy was subject to subrogation and only applicable after Client's primary private health insurance had been exhausted.

On April 29, 2019, Defendants notified Plaintiff via email of the foregoing issues, stating:

> Because the at-fault party only had $30,000.00 and [Client's] Underinsured Motorist Coverage does not apply, **ALL of the treatment [Client] has received (and will continue to receive) must be filed under his private health insurance.** We cannot honor anymore treatment under a Letter of Protection. Please note [Client] file accordingly.

Compl. ¶ 29 (emphasis in original).[2]

On May 2, 2019, Highsmith performed additional surgery on Client, charging him an additional $62,451.87 (Second Surgery). **Ex. F**. In total, Plaintiff charged Client $125,409.28. **Ex. F.** Despite receiving explicit instructions regarding claim submission and payment on several occasions prior to both surgeries, Plaintiff did not file claims with Client's private health insurance. On January 3, 2020, Bennett wrote Goodwine and reminded her of the Letters of Protection and that it appeared Client's health insurance did not pay any of Plaintiff's bills. **Ex.**

[2] It is anticipated Plaintiff may contest the authenticity of the email. However, Plaintiff's complaint alleges the email was sent to it and Defendants admitted the allegation in their answer. ***Compare* Compl. ¶29 *with* Ans. ¶29.** Because Defendants admitted the fact as Plaintiff pled it, it is conclusively proven for the purposes of trial.

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G. Bennett explained there was only $30,000 in coverage to pay the claim and they needed to discuss how to allocate that amount amongst everyone. **Ex. G.**

Because Client has been unable to pay for Plaintiff's services, Plaintiff initiated a debt collection action against him on May 21, 2021. Further, Plaintiff has demanded payment from Defendants for Client's medical bills. Defendants have attempted to tender payment to Plaintiff out of the settlement proceeds, and Plaintiff refused it. Moreover, the settlement proceeds are currently being held in Defendant Law Firm's trust account, and Defendants will not receive any of the funds upon resolution of this matter.

Despite Defendants' offer to pay Plaintiff out of the settlement proceeds, Plaintiff filed this action on July 22, 2021. Defendants moved to dismiss Plaintiff's claims, which was granted in part and the only remaining claims are for (1) Breach of Contract and (2) Violation of the SC Unfair Trade Practices Act.

STANDARD OF REVIEW

"Summary judgment is appropriate 'if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.'" *Russell v. Wachovia Bank, N.A.*, 353 S.C. 208, 217, 578 S.E.2d 329, 334 (2003) (quoting Rule 56(c), SCRCP). Summary judgment's purpose is to expedite the disposition of cases not requiring a fact finder. *Nakatsu v. Encompass Indem. Co.*, 390 S.C. 172, 177, 700 S.E.2d 283, 286 (Ct. App. 2010).

The burden of proof rests with the party seeking summary judgment; however, the non-moving party must make a showing sufficient to establish the existence of an essential element on which it will bear the burden to prove at trial. *Baughman v. Am. Tel. & Tel. Co.*, 306 S.C. 101,

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115, 410 S.E.2d 537, 545 (1991). In determining whether summary judgment is appropriate, the evidence is viewed in the light most favorable to the non-moving party. *Edgewater on Broad Creek Owners Ass'n, Inc. v. Ephesian Ventures, LLC,* 430 S.C. 400, 407, 845 S.E.2d 211, 214 (Ct. App. 2020).

The South Carolina Supreme Court recently clarified that the "mere scintilla" standard does not apply to defeat summary judgment, but instead the party must establish a genuine issue of material fact. *Kitchen Planners, LLC v. Friedman*, 440 S.C. 456, 463, 892 S.E.2d 297, 301 (2023). "A fact is material if it 'might affect the outcome of the suit under the governing law.'" *Libertarian Party of Va. v. Judd*, 718 F.3d 308, 313 (4th Cir. 2013) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)). A dispute is "genuine" if "a reasonable jury could return a verdict for the non-moving party." *Strothers v. City of Laurel*, 895 F.3d 317, 326 (4th Cir. 2018) (quoting *Anderson*, 477 U.S. at 248). It is not sufficient for a party to create an inference that is not reasonable or an issue of fact that is not genuine. *Town of Hollywood v. Floyd*, 403 S.C. 466, 477, 744 S.E.2d 161, 166 (2013).

ARGUMENT

I. This Court should grant Defendants summary judgment because they did not breach any material term of any contract with Plaintiff.

To succeed on a breach of contract claim a plaintiff must establish (1) the existence of a contract, (2) its breach, and (3) the damages caused by the breach. *Branche Builders, Inc. v. Coggins*¸ 386 S.C. 43, 48, 686 S.E.2d 200, 202 (Ct. App. 2009). "The general rule is that for a breach of contract the [breaching party] is liable for whatever damages follow as a natural consequence and a proximate result of such breach." *S. Glass & Plastics Co. v. Kemper*, 399 S.C. 483, 492, 732 S.E.2d 205, 209 (Ct. App. 2012) (quoting *Fuller v. E. Fire & Cas. Ins. Co.*, 240 S.C. 75, 89, 124 S.E.2d 602, 610 (1962)).

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Plaintiff alleges generally that it entered into a contract with Defendant, referring to the Letter of Protection. **Compl. ¶ 41**. Plaintiff alleges that it fulfilled all necessary preconditions, and that Defendants breached the Letter of Protection. **Compl. ¶¶ 42-43**.

A. There was no contract between Plaintiff and Defendants because Defendants did not manifest a willingness to pay for Client's medical bills and Plaintiff did not accept by providing medical services conditioned on a promise to pay the bills.

"The necessary elements of a contract are an offer, acceptance, and valuable consideration." *Sauner v. Pub. Serv. Auth. of S.C.*, 354 S.C. 397, 406, 581 S.E.2d 161, 166 (2003). "An offer is the manifestation of willingness to enter into a bargain, so made as to justify another person in understanding that his assent to that bargain is invited and will conclude it." *Carolina Amusement Co. v. Connecticut Nat'l Life Ins. Co.*, 313 S.C. 215, 437 S.E.2d 122 (Ct. App. 1993) (quoting Restatement (Second) of Contracts § 24 (1981)). A valid offer "identifies the bargained for exchange and creates a power of acceptance in the offeree." *Id.* "To be binding, an offer must be definite. *Prescott v. Farmers Tel. Co-op., Inc.*, 335 S.C. 330, 336–37, 516 S.E.2d 923, 926 (1999). Also, it must "be one which is intended of itself to create legal relations on acceptance." *Id.*(quoting *McLaurin v. Hamer*, 165 S.C. 411, 420, 164 S.E. 2, 5 (1932)).

"Acceptance of an offer is a manifestation of assent to the terms thereof made by the offeree in a manner invited or required by the offer." *Electro-Lab of Aiken, Inc. v. Sharp Constr. Co. of Sumter*, 357 S.C. 363, 369, 593 S.E.2d 170, 173 (Ct. App. 2004) (quoting Restatement (Second) of Contracts § 50 (1981)). "A typical contract contains mutual promises and is created by an acceptance constituting a return promise by the offeree." *Id.* "Moreover, a contract only arises when there is an actual agreement by the parties in which the parties demonstrate a mutual intent to be bound." *Id.*

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There was no legally enforceable contract between Plaintiff and Defendants with a term requiring Defendants be personally liable for Client's medical bills. Plaintiff is alleging that the Letters of Protection created a contract between it and Defendants. However, there was not an offer or an acceptance.

The language of the Letters of Protection does not constitute an offer, regardless of using the term "agreement." The March 2019 Letter of Protection, which was in place before any surgeries, stated:

> Please accept this correspondence as our Law Firm's agreement to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance.

Dr. Highsmith confirmed the language in the Letters of Protection are the only way he has to try and hold Defendants responsible for Client's medical bills. **Ex. H (Dr. Highsmith Depo. Tr. 33:22 – 34:7)**. The language in the letter is not definite, and does not "identify the bargained for exchange" and create "a power of acceptance" in Plaintiff. The language does not contain a bargained for exchange identifying what Plaintiff is giving in exchange for the protection. The language does not create a power of acceptance because it does not identify what Plaintiff would need to do (or refrain from doing) in order to accept. Without language identifying the bargained for exchange, there can be no contract. Also, without language identifying what Plaintiff would need to do to accept, there can be no offer and no contract.

Even if the Letter of Protection was an offer, Plaintiff did not communicate any acceptance in the manner invited or required by the offer. Plaintiff will most likely argue that it accepted by providing treatment to Client. First, the offer did not identify that Plaintiff could

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accept by providing treatment and, therefore, Plaintiff could not have accepted in the manner invited or required by the offer.

Second, Plaintiff did not rely on the offer in order to provide care to Client. Dr. Highsmith testified he generally was not concerned about getting a letter of protection before providing treatment **(Ex. H (15:19-21));** he didn't notice when letters of protection came in and they did not seek them out **(Ex. H (15:12-16)**; he has a financial policy that says the patient is responsible for the bill **(Ex. H (15:16-18))**; and he would treat a patient either way with or without a letter of protection **(Ex. H (16:13-24))**.

In addition, Dr. Highsmith testified numerous times that he did not know when he read the letters, but assumes that it was at some point when he provided treatment **(Ex. H (41:1-12; 55:22-56:4))**; and that he and his staff would discuss letters of protection but not prior to providing services **(Ex. H (41:22 – 42:1))**. It would be unreasonable to infer that Plaintiff "accepted" any terms of an offer by agreeing to provide treatment to Client when Dr. Highsmith testified he does not know when he got the Letter of Protection, would have treated without it, and relies on his financial policy the patient signs. Because there is no reasonable inference from the evidence that Plaintiff agreed to provide services to Client based on the Letter of Protection, there is no acceptance and no contract.

Ultimately, in order to impose the liability Plaintiff alleges (Defendants are responsible for Client's medical bills), the language in the letter would need to be definite and show that Defendants agreed to be responsible for the medical bills. But Dr. Highsmith agreed there is no language in the letter stating the law firm would be responsible for the medical bills if there was an insufficient recovery. *See* **Ex. H (75:4-8))**. Even in the absence of Dr. Highsmith's acknowledgment, the only reasonable inference is there was no contract obligating the

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Defendants to pay for Client's medical bills. The language contemplates the possibility of an insufficient recovery and explains what will occur in that scenario: the client (not Defendants) will be responsible. Because the language indicates the client will be responsible in the event of an insufficient recovery, and Dr. Highsmith agreed the language does not state the law firm would be responsible, the only reasonable interpretation is that there is no contract obligating Defendants to pay for the medical bills in the event of an insufficient recovery.

Stated simply, the Letters of Protection cannot be reasonably interpreted to create a contract that Defendants offered to be responsible for Client's medical bills if Plaintiff agreed to provide medical services to Client, and Plaintiff actually provided medical services based on that offer. Without that offer and acceptance, there is no contract. At most, the Letters of Protection amounts to a gratuitous promise. Accordingly, this Court should dismiss Plaintiff's claim for breach of contract.

B. Assuming there was an enforceable contract between Plaintiff and Defendant Law Firm, Defendants have not breached any terms of the agreement.

Actions for breach of contract must be based on the terms in the contract. *Maybank v. BB&T Corp.*, 416 S.C. 541, 573, 787 S.E.2d 498, 515 (2016). The question of whether a contract is ambiguous is one for the court, and for unambiguous contracts the court's responsibility is to construe the contract as a matter of law. *See Crenshaw v. Erskine College*, 432 S.C. 1, 26, 850 S.E.2d 1, 14 (2020). "A contract is ambiguous when it is capable of more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business." *Hawkins v. Greenwood Dev. Corp.*, 328 S.C. 585, 493 S.E.2d 875, 878 (Ct. App. 1997). "[A] court's ultimate duty is confined to interpreting the contractual provisions agreed to by the parties—

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regardless of their wisdom or folly, apparent unreasonableness, or any failure of the parties to guard their interests carefully." *Maybank*, 416 S.C. at 574, 787 S.E.2d at 515.

"[O]ne who seeks to recover damages for breach of a contract must demonstrate that he has performed his part of the contract, 'or at least that he was, at the appropriate time, able, ready, and willing to perform it.'" *Hotel & Motel Holdings, LLC v. BJC Enterprises, LLC*, 414 S.C. 635, 652, 780 S.E.2d 263, 272–73 (Ct. App. 2015) (quoting *Swinton Creek Nursery v. Edisto Farm Credit, ACA*, 334 S.C. 469, 487, 514 S.E.2d 126, 135 (1999)).

Here, before any surgeries, the agreement between the parties was initially that the law firm would (1) protect any claim that Plaintiff had "out of any settlement proceeds [law firm] may receive arising out of the incident," and (2) Client remained personally responsible for any outstanding balance "in the event of insufficient recovery." This was modified when Tina Bennett canceled the first Letter of Protection, explaining that all treatment should proceed under Client's private health insurance, to which Plaintiff agreed. With the understanding that private health insurance would be billed first, Defendants sent a new Letter of Protection agreeing (1) to protect any portion of [Plaintiff's] bill not paid by private health insurance out of settlement proceeds, and (2) that Client remained personally liable in the event of insufficient recovery. Seven days after this Letter of Protection, Dr. Highsmith performed the First Surgery.

However, Plaintiff never billed Client's private health insurance. *See* **Ex. H (93:13-18)**. Further, the parties only collected $30,000 in settlement proceeds. **Ex. G.** Defendants attempted to work with Plaintiff in splitting the settlement proceeds amongst the medical providers, but Plaintiff refused. The $30,000 in settlement proceeds is still sitting in Defendants' trust account awaiting resolution of this matter.

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According to the unambiguous language of the latest Letter of Protection, Plaintiff was required to bill Client's private health insurance. In addition, the language unambiguously limits Defendants' responsibility to protection of a claim to the settlement proceeds. Finally, the language references the possibility of an insufficient recovery and who would be responsible if there was an insufficient recovery—Client, not Defendants. Dr. Highsmith, the principal for Plaintiff, agreed the language in the Letter of Protection was limited to settlement proceeds recovered. **Ex. H (73:25-74:10)**. Furthermore, Dr. Highsmith understood the possibility of an insufficient recovery because the letters indicated that Client would be responsible in that scenario, and that nothing in the letters indicated the Law Firm would be responsible for the medical bills in the event of an insufficient recovery. **Ex. H (74:23-75:8)**.

At no time did Plaintiff bill Client's health insurance, which was a precondition to any "protection" of settlement proceeds. Plaintiff failed to comply with its obligations under the contract by failing to bill health insurance. Regardless, the letter stated Defendants would "protect" portions of the bill not paid by health insurance out of settlement proceeds they received. Defendants obtained $30,000 in settlement proceeds and those proceeds are in the trust account. Defendants have attempted to resolve competing claims to those proceeds between two medical providers, including Plaintiff. That proposal to divvy up the proceeds included Client and Defendants waiving any right to the funds. In short, Defendants have protected any claims of Plaintiff to the settlement proceeds.

In addition, the Letter of Protection makes clear that Client will remain responsible for his own medical bills. Plaintiff acknowledged that portion of the letter, had its own financial policy making Client responsible for his medical bills, and sued and resolved claims against Client for payment of the medical bills.

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Because Defendants have not disbursed any of the settlement proceeds they received, and are willing to disburse them to competing medical providers, Defendants have protected Plaintiff's claims to the settlement proceeds and have not breached any agreement with Plaintiff. Moreover, the Letters of Protection made clear Client was responsible for his own bills, and Plaintiff actively pursued and resolved claims against Client consistent with this understanding. Therefore, there has been no breach of any contract, and this Court should dismiss Plaintiff's breach of contract claim.

II. This Court should grant Defendants summary judgment because they did not violate the South Carolina Unfair Trade Practice Act.

SCUTPA makes unlawful "unfair or deceptive acts or practices in the conduct of any trade or commerce." S.C. Code Ann. § 39-5-20(a). "Unfair" acts are acts that offend public policy or are immoral, unethical, or oppressive. *Bessinger v. Bi-Lo, Inc.*, 366 S.C. 426, 432, 622 S.E.2d 564, 567 (Ct. App. 2005). "Deceptive" acts are acts that have a tendency to deceive. *Health Promotion Specialists, LLC v. S.C. Bd. of Dentistry*, 403 S.C. 623, 638, 743 S.E.2d 808, 816 (2013).

To state a claim under SCUTPA, a plaintiff must show "(1) the defendant engaged in an unfair or deceptive act in the conduct of trade or commerce; (2) the unfair or deceptive act affected [the] public interest; and (3) the plaintiff suffered monetary or property loss as a result of the defendant's unfair or deceptive act(s)." *Health Promotion Specialists, LLC v. S.C. Bd. of Dentistry*, 403 S.C. 623, 638, 743 S.E.2d 808, 816 (2013) (quoting *Wright v. Craft*, 372 S.C. 1, 23, 640 S.E.2d 486, 498 (Ct. App. 2006)). A "deliberate or intentional breach of a valid contract, without more, does not constitute a violation of the Unfair Trade Practices Act." *Columbia E. Assocs. v. Bi-Lo, Inc.*, 299 S.C. 515, 522, 386 S.E.2d 259, 263 (Ct. App. 1989) (affirming trial court dismissal of SCUTPA claim based on breach of commercial lease agreement).

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"The legislature intended in enacting [SCUTPA] to control and eliminate 'the large scale use of unfair and deceptive trade practices within the state of South Carolina.'" *Noack Enterprises, Inc. v. Country Corner Interiors of Hilton Head Island, Inc.*, 290 S.C. 475, 477, 351 S.E.2d 347, 349 (Ct. App. 1986) (quoting Note, *Consumer Protection and the Proposed "South Carolina Unfair Trade Practices Act*," 22 S.C.L.REV. 767, 787 (1970)). This is why SCUTPA requires the unfair or deceptive act to affect the people of South Carolina. *Id.* The purpose of the limitation is to circumscribe the "kind of trade or commerce" that can serve as a basis for a SCUTPA claim. *Id.* "An unfair or deceptive act or practice that affects only the parties to a trade or a commercial transaction is beyond the act's embrace . . . ." *Id.* at 479, 351 S.E.2d at 349-50.

Here, Plaintiff's complaint contains merely a formulaic recitation of the elements of a SCUTPA claim. The complaint does not specifically allege what acts were "unfair or deceptive" or what ascertainable loss of money Plaintiff suffered. In discovery, Plaintiff stated it is "unfair or deceptive" to "make representations, assurances, and promises to a healthcare provider that payments for elective surgical procedures to be rendered by the healthcare provider . . . would be paid out of $1,100,000 of liability coverage available to the at-fault party who allegedly injured the lawyer's client when the lawyer and law firm did not verify the availability of the insurance coverage before making the representations to the healthcare provider." Plaintiff also alleges Defendants knew Plaintiff was an out-of-network provider. **Ex. I (Pltf's ATI)**.

The email from Ms. Bennett stated, in pertinent part, that they did not know the limits of the liability coverage and because Client "carries $100,000.00 in Underinsured Motorist Coverage on his at-home policy with Safeco, and there is $1,000,000 in "Occupational Accident Coverage" to pay bills and wages under the One Beacon Policy, we are not concerned that there will be enough over all coverage to pay the claim." **Ex. C**. Hours later that same day, once

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Defendants knew Client needed surgery, Ms. Bennett informed Plaintiff the treatment should be filed with private health insurance and it "would be best for everyone involved if we NOT do the treatment under an Assignment/Letter of Protection." **Ex. C**. Plaintiff's employee responded "Okay thanks for the update." **Ex. C**.

A. The only reasonable inference from the evidence is that Defendants did not know Plaintiff was an out-of-network provider when Defendants made statements about the other policies.

Defendants did not know Plaintiff was considered "out-of-network" with Client's health insurer, BlueCross BlueShield. Defendant testified that it did not know Plaintiff was out-of-network. *See* **Ex. J (D&M Depo. Tr. 48:16-49:7)**. There is no evidence in the record to establish, or support a reasonable inference, that Defendants knew that Plaintiff was out-of-network at any time before Plaintiff stopped providing Client medical care. It is anticipated Plaintiff may rely on its Financial Policy, but there is no evidence to show that Defendants received the policy. *See* **Ex. J (18:14-19:10); Ex. J (24:3-5)** ("We didn't know anything between [Client] and Dr. Highsmith. He went to Dr. Highsmith, and they didn't send us a copy of anything that he filled out."). Moreover, the language in the Financial Policy does not clearly state Plaintiff is out of network, and Plaintiff's actions establish the opposite when they requested, and Client provided, his health insurance card for the first surgery.

Further, Plaintiff, knowing it was out of network, should have said something in response to the Letter of Protection and emails requiring that treatment be provided through and billed to Client's insurer. *See* **Ex. J (49:10-20).** The fact that Defendant's employee made that request shows that it did not know Plaintiff was out-of-network and assumed the opposite. None of Plaintiff's employees corrected that misunderstanding. In fact, Plaintiff's employee responded and agreed to abide by the request to bill Client's health insurer when she said "Okay." Thus,

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contrary to Plaintiff's allegation, there is no evidence to establish that Defendants knew at the time of the initial statements about coverage and that Plaintiff was out-of-network.

B. Plaintiff's allegations of the "unfair or deceptive" act are unsupported by the evidence.

Plaintiff alleges it was unfair or deceptive to "make representations, assurances, and promises to a healthcare provider that payments for elective surgical procedures to be rendered by the healthcare provider . . . would be paid out of $1,100,000 of liability coverage available to the at-fault party." The only reasonable inference from the evidence is that Defendants never represented, promised or assured that Plaintiff would be paid out of "$1,100,00 of liability coverage available to the at-fault party."

Bennett explained that the at-fault party had North Carolina auto insurance, and would not release the limits without a medical authorization that they were not willing to provide. **Ex. C.** Thus, Defendants did not know what liability insurance was available to the at-fault party. Moreover, Bennett explained that *Client* had a UIM policy and an Occupational Accident Coverage policy. This was not liability coverage available to the at-fault party. In fact, the policy names imply certain preconditions to coverage that Plaintiff was unaware of at the time. Plaintiff could not have known if the $100,000 in underinsured motorist coverage applied, because no one at the time knew if the at-fault party was underinsured. Further, the name of the One Beacon policy—Occupational Accident Coverage—implies that the accident would need to occur within Client's occupation, which Plaintiff was unaware of at the time. Essentially, Bennett never made any representation, promise, or assurance that *Plaintiff's medical bills* would be paid out of those policies. Instead, she expressed that they were not concerned about there being enough overall coverage to cover the claim. This is not tantamount to an assurance, promise, or representation that Plaintiff's medical bills would be paid out of those amounts.

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Accordingly, the unfair or deceptive act on which Plaintiff relies is a mischaracterization of the statements by Bennett, unsupported by any evidence or reasonable inferences therefrom.

C. Even if Plaintiff's unfair or deceptive act allegations were generally about referencing coverage at all, there is no evidence or reasonable inferences from evidence to show that Defendants' statements about coverage were unfair or deceptive.

The references to coverage cannot be an unfair or deceptive act because the statement, when made, was accurate. Kiara Goodwine asked Bennett in general what the "limits" were for Client. **Ex. C.** Ms. Bennett stated that Client "carried" a policy with Safeco with $100,000 in UIM and One Beacon Policy for "Occupational Accident Coverage" for $1,000,000. That was a truthful statement of the limits of those policies, and remains true. *See* **Ex. J (50: 3-7)**. Client had those policies in effect when Bennett told Kiara Goodwine. In addition, Ms. Bennett mentioned that they were "not concerned that there will be enough overall coverage to pay the claim." Again, this statement was true at the time made and only a representation about their concern about coverage. Because they were true when made, it is hard to fathom how it could constitute unfair or deceptive practice.

Even though Ms. Bennett said they were "not concerned," she followed up that same day after she found out that Client needed surgery, explaining to Plaintiff's employee that all of Client's surgical treatment was to be filed with his private health insurance company, and that the treatment should not proceed under an assignment or Letter of Protection. As Defendant testified, this shows that Defendants were concerned about coverage. *See* **Ex. J (53:2-17)**. Thus, Plaintiff knew after any statements about policies, that it was to process payment through the private health insurer—not the UIM policy or occupational policy limits. Also, Plaintiff's employee did not bat an eye at the request for Plaintiff to submit claims to health insurance, instead agreeing to do so when she said "Okay thanks for the update."

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Finally, after Ms. Bennett informed Kiara about the Safeco and One Beacon policies, the Letter of Protection explained what would occur in the event of an insufficient recovery—Client would be responsible. The reference to "insufficient recovery" is directly contrary to Plaintiff's belief forming the basis for the SCUTPA claim—the belief there would be a sufficient recovery on the policies mentioned to pay the claim. Dr. Highsmith agreed the letter outlined who would be responsible in the event of an insufficient recovery—the Client and not Defendants. **Ex. H (74:23-75:8)**.

Because the general references to other policies were true at the time, Bennett notified Plaintiff it should seek payment for its surgical services from Client's health insurer, and the subsequent letter informed Plaintiff of the possibility of an insufficient recovery, the statements about the other policies were not unfair or deceptive, and this Court should grant Defendants summary judgment on the SCUTPA claim.

D. Plaintiff cannot establish Defendants' alleged unfair or deceptive acts proximately caused an ascertainable loss of money or property.

In order to recover actual damages under SCUTPA, the plaintiff must establish that the damages are the "natural and proximate result of deceptive conduct." *Wright v. Craft*, 372 S.C. 1, 24, 640 S.E.2d 486, 499 (Ct. App. 2006); *see Collins Holding Corp. v. Defibaugh*, 373 S.E.2d at 446, 451, 646 S.E.2d 147, 150 (Ct. App. 2007) (finding the trial court erred in finding for plaintiff on SCUTPA claim because plaintiff did not establish the deceptive act (reflexive payout on gaming machines) was the cause of the plaintiff's machines earning less money).

As indicated above, Plaintiff has a financial policy that says the patient is responsible for the bill and he relies on that financial policy. **Ex. H (15:16-18)**. In addition, Dr. Highsmith testified that coverages do not affect his treatment recommendation. He stated that "if it's an elective surgery, [he] is not going to put someone through a huge bill if there's supposed

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coverage that doesn't exist". But Dr. Highsmith testified that the Client needed the surgery. *See* **Ex. H (104:6-105:5)**. He also testified that, in a situation where a patient needs surgery and he doesn't know anything about what insurance coverage is, he would still provide the surgery. **Ex. H (66:22-67:1)**.

Moreover, Dr. Highsmith testified that he did not know whether he saw the email from Bennett referencing insurance policies prior to providing services to Client, and further that the substance of the emails about coverage were not relevant to Client's medical care. *See* **Ex. H (Tr. 69:14-70:3).**

The only reasonable inference from the evidence above is that Plaintiff did not rely on statements about insurance coverage from Ms. Bennett to provide medical care to Client. If he did not rely on those statements, those statements could not have proximately caused him damages, i.e., caused it to render medical services it thought would be covered by insurance that supposedly were not covered. Without a reasonable inference to support causation, Plaintiff's claim for SCUTPA fails, and this Court should grant Defendants summary judgment.

E. This Court should dismiss the SCUTPA claim because the actions alleged to support the claim affect only the parties to the transaction.

"To be actionable under the UTPA, an unfair or deceptive practice or act must adversely affect the public interest." *Jefferies v. Phillips*, 316 S.C. 523, 527, 451 S.E.2d 21, 23 (Ct. App. 1994). "Therefore, conduct [that] only affects the parties to the transaction provides no basis for a UTPA claim." *Id.* "The act is not available to redress a private wrong . . . ." *Columbia East Assoc. v. Bi-Lo, Inc.*, 299 S.C. 515, 386 S.E.2d 259 (Ct. App. 1989).

The plaintiff must prove the impact on public interest based on specific facts, without which the court would be left to speculate on the public impact and that will not support a UTPA claim. *Jeffries*, 316 S.C. at 527, 451 S.E.2d at 23. The court must analyze each case and

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determine whether the wrongful conduct impacts the public, either through circumstances of the transaction or by evidence of similar acts. *Id.* at 529, 451 S.E.2d at 23.

"In the course of human endeavor, every action has some potential for repetition. The mere proof that the actor is still alive and engaged in the same business is not sufficient to establish this element." *Id.*, 451 S.E.2d at 24 (finding there was no evidence of similar acts or facts to establish the conduct has potential for repetition in claim that a contractor overcharged for termite repair work, even though there were allegations the contractor might pad other bills).

Plaintiff is attempting to use SCUTPA to redress a private wrong where only parties to the transaction are impacted. There is no evidence of similar acts or facts to establish the conduct has potential for repetition and, therefore, Plaintiff fails to show an impact on public interest.

Plaintiff alleges a violation occurred when Bennett made "representations, assurances, and promises to a healthcare provider that payments for elective surgical procedures to be rendered by the healthcare provider . . . would be paid out of $1,100,000 of liability coverage available to the at-fault party." First, the circumstances of this "transaction" establishes that it affected only the parties. The statement was in response to Plaintiff's solicitation about Client's "limits", was based on the Client's case, his need for medical care, and what insurance policies the Client had. The circumstances are unique, entirely dependent on the facts of each matter. Therefore, there is no potential impact on the public interest.

Further, there is no evidence in this case that Defendants made similar statements in other cases before Client's case and treatment. Therefore, there is no affect on the public interest based on previous similar acts.

Importantly, the deposition testimony and any allegations about Defendants sending similar letters of protection in previous cases cannot be used to establish an impact on the public

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interest because Plaintiff is relying on statements about insurance coverage. Just because Defendants continue to exist and practice law representing injured plaintiffs, is not sufficient to show that any conduct could be repeated. The only parties affected are the parties to the transaction, and there is no evidence or reasonable inference from the evidence to create a genuine issue of material fact that Defendants' conduct could impact the public interest. Accordingly, this Court should grant Defendants summary judgment.

F. Finally, One Beacon eventually accepted coverage under its policy, although it did not pay Plaintiff's bills in full.

While this litigation and the litigation against Client has been ongoing, Plaintiff eventually submitted its bills to One Beacon under Client's Occupational Accident Policy. One Beacon paid Plaintiff something for each one of the services Plaintiff rendered to Client that is the subject of this action. **Ex. K (EOB); Ex. L (Check)**.

One Beacon included in its payment an explanation of benefits stating on each of the eight pages that "the patient is covered under an Occupational Accident Policy." **Ex. K; Ex. L**. It also explained that "[u]nless otherwise noted, charges were reduced by the lesser of the usual and customary charges for the service, treatment or supply as reflected in the local Workers' Compensation schedule or negotiated rate." Comparing the explanation of benefits to the full list of charges for services to Client it is clear that One Beacon paid an amount for each one of the charges. **Compare Ex. F to Ex. K**.

Clearly, One Beacon found there was coverage under its Occupational Accident Policy that had the $1,000,000 in coverage, even though it did not pay what Plaintiff wanted. Because One Beacon found coverage under that policy in the course of this litigation, it is incredible to continue to assert that Bennett's statements in one email were unfair and deceptive. Accordingly, this Court should grant Defendants summary judgment.

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CONCLUSION

This Court should grant Defendants summary judgment because, even in the light most favorable to Plaintiff, there is no genuine issue of material fact that Defendants did not breach any contract to Plaintiff and did not violate the South Carolina Unfair Trade Practice Act.

This 14th day of August, 2024.

Respectfully submitted,

COPELAND, STAIR, VALZ & LOVELL, LLP

By: *s/Skyler C. Wilson*
DOUGLAS W. MACKELCAN
State Bar No.: 76332
SKYLER C. WILSON
State Bar No.: 102865
Attorneys for Defendants

40 Calhoun Street, Suite 400
Charleston, SC 29401-3531
dmackelcan@csvl.law
swilson@csvl.law
Ph: 843-727-0307

EXHIBIT
A

DELUCA MAUCHER
LAW OFFICES

MICHAEL A. MAUCHER
MIKE@DELUCAMAUCHER.COM
(O) (843) 572-1711 • (F) (843) 572-1285
REPLY TO GOOSE CREEK OFFICE

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December 20, 2018

FAX MAIL
(843) 553-1008

Jason H. Highsmith, M.D.
9313 Medical Plaza Drive, Suite 303
Charleston, South Carolina 29406

RE: My Client: Scott DeMaskey
Date of Accident: 12/14/18

Dear Sir or Madam:

With regard to the above-named individual, please accept this correspondence as our Law Firm's agreement to protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding account balance.

With kindest regards, I am,

Very truly yours,

Michael A. Maucher

Michael A. Maucher

MAM/tgb
NOTE: To ensure that this office is aware of your medical lien, please provide an itemized billing statement for services rendered.

DEFENDANT'S EXHIBIT 1
tabbies MR 5/19/23
Highsmith

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****
*** FAX TX REPORT ***
****

TRANSMISSION OK

JOB NO.	4427
DESTINATION ADDRESS	8435531008
SUBADDRESS	
DESTINATION ID	
ST. TIME	12/21 02:12
TX/RX TIME	00' 37
PGS.	1
RESULT	OK

DM

DeLUCA MAUCHER

LAW OFFICES

MICHAEL A. MAUCHER
MIKE@DELUCAMAUCHER.COM
(O) (843) 572-1711 ' (F) (843) 572-1285
REPLY TO GOOSE CREEK OFFICE

December 20, 2018

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(843) 553-1008

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9313 Medical Plaza Drive, Suite 303
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With regard to the above-named individual, please accept this correspondence as our Law Firm's agreement to protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding account balance.

With kindest regards, I am,

Very truly yours,

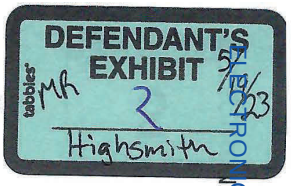
Michael A. Maucher

MAM/tgb

Fax: (843) 474-0712

EXHIBIT B

Fax: (843) 474-0712



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FINANCIAL POLICY

- **BASIC POLICY:** The patient is responsible for medical bills in our office. Our staff will help with completion of insurance forms as an accommodation and convenience to you without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us, and to negotiate with your insurance company over any disputed claims.
- **IF YOU DO NOT HAVE INSURANCE:** Our policy requires payment in full today, unless other arrangements are made. If you cannot pay in full now, we request partial payment today as you arranged for credit on your account with a payment plan agreement with our credit and collection manager.
- **IF YOU HAVE INSURANCE:** Fill out the insurance section of our form, Carolina Neurosurgery & Orthopedics, Inc. does not accept Medicare, Medicaid or any HMO plan. If you are covered by private insurance or PPO with out of network benefits, please present your identification card to the receptionist at the time of your appointment. I understand, as a courtesy, Carolina Neurosurgery & Orthopedics, Inc. will file with my primary insurance. If after 90 (ninety) days from the date of service from the date of service and/or surgery insurance has not paid, the total balance will be considered due and payable. The Medical Providers are out of network and you may be responsible all or part of your balance.
- **WORKMAN'S COMPENSATION:** In the event it is determined by the worker's compensation board that the illness or injury is not a result of a compensable worker's compensation case, I hereby agree to pay the usual and customer fees for the services rendered.
- **REJECTED CLAIMS:** If your insurance company rejects your claim, or if they pay less than the total bill, our policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay your balance in full after your insurance payment, please call Carolina Neurosurgery & Orthopedics, Inc. and make arrangements to pay your bill.
- **FORMS OF PAYMENT:** We accept payments in cash, check, or money order. Checks must be made payable to Carolina Neurosurgery & Orthopedics, Inc.
- **RETURNED CHECKS:** A $100.00 handling charge is applied to all returned checks.
- **DELINQUENT ACCOUNTS:** Delinquent accounts over 90 days are turned over to our collection manager, unless other arrangements are made. If the bill remains unpaid and satisfactory arrangements for payment are not made, the collection manager will review the account with the doctor to decide appropriate legal action including placing a lien on a third-party case. We reserve the right to addition late charges to delinquent accounts requiring collections action and to addition attorney fees, court costs, and/or collections agency fees. If your account is placed with a 3rd party, they have the right to contact you at any number provided to our office.
- **MONTHLY STATEMENTS:** Once your insurance has paid you are responsible for the unpaid balance. You will receive an itemized monthly statement of any patient balance until your bill is paid in full. Interest of 1.5% (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of $0.50 per month.

If this account is assigned to an attorney for collections and/or suit, Carolina Neurosurgery & Orthopedics, Inc. will be entitled to all attorney's fees and costs of collection.

I hereby authorize payment to healthcare provider for all funds owing to me from my case by way of insurance payments, judgment, verdict or other source which may be paid to my attorney or myself.

In addition to my foregoing, in order to secure my obligation to pay the amount of my charges to healthcare provider, and in consideration for healthcare provider's agreements set forth herein, I hereby grant to healthcare provider, in accordance with the uniform commercial code as in effect in the applicable jurisdiction, a security interest in and lien upon: (I) the proceeds; and (II) all proceeds thereof, in each aseptic whether now owned or hereafter existing, acquired or arising, and wherever located. I authorize healthcare provider to file one or more UCC Financing statements (and continuations thereof) naming me as debtor and evidencing healthcare provider's security interest in such collateral. I hereby authorize my attorney to pay healthcare provider from any proceeds of any settlement, if applicable.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure my records to any third party.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and other health plan.

This assignment may not be revoked by me or anyone else. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I have read and agree to the financial policy of this office.

Scott D

Patient Signature

Appointment Date: 1-3-2019

EXHIBIT C

Tina

From: Kiara Goodwine <kiara@orthoandneuro.com>
Sent: Monday, January 21, 2019 12:11 PM
To: Tina
Cc: 'Scott DeMaskey'
Subject: Re: Scott DeMaskey

Okay thanks for the update !

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Tina <Tina@delucamaucher.com>
Sent: Monday, January 21, 2019 11:58:35 AM
To: Kiara Goodwine
Cc: 'Scott DeMaskey'
Subject: Scott DeMaskey

Kiara,

Scott DeMaskey has advised our office that he will require surgery. Based upon the serious nature of his injury, and his pre-existing injuries, we would respectfully request that all of his treatment be filed with his private health insurance company. It would be best for everyone involved if we NOT do the treatment under an Assignment/Letter of Protection.

On a separate matter, please provide this office with the office note and/or documentation which shows the recommended surgery.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

DEFENDANT'S EXHIBIT 5/19/23 Highsmith

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Tina

From: Tina
Sent: Monday, January 21, 2019 9:24 AM
To: 'Klara Goodwine'
Cc: Brooke Dunsil; Kary Garcia
Subject: RE: Scott Demaskey

Kiara,

The at-fault party had a North Carolina Policy of automobile insurance. In order for them to disclosure the limits of their North Carolina Policy, we must provide them with a signed Medical Authorization allowing them to obtain copies of Scott Demaskey's medical records. We are NOT willing to comply with that request. We are therefore unable to find out how much Liability Coverage is on their policy. Because Mr. Demaskey carries $100,000.00 in Underinsured Motorist Coverage on his at-home policy with Safeco, and there is $1,000,000.00 in "Occupational Accident Coverage" to pay bills and wages under the One Beacon Policy, we are not concerned that there will be enough over all coverage to pay the claim.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

From: Kiara Goodwine [mailto:klara@orthoandneuro.com]
Sent: Wednesday, January 16, 2019 4:12 PM
To: Tina
Cc: Brooke Dunsil; Kary Garcia
Subject: Scott Demaskey

Good afternoon,

May I please get limits on patient Scott Demaskey DOB Reda /54

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

Subject: **Fw: Scott Demaskey**
Date: 1/3/2020 2:21:54 PM Eastern Standard Time
From: kiara@orthoandneuro.com
To: edweinberger@aol.com

EXHIBIT D

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Tina <Tina@delucamaucher.com>
Sent: Thursday, March 7, 2019 9:34 AM
To: Kiara Goodwine <kiara@orthoandneuro.com>
Subject: Scott Demaskey

Please see attached LOP. This LOP covers whatever is NOT paid by private health insurance.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

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DEFENDANT'S EXHIBIT 4 5/19/23 MR Highsmith

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DELUCA MAUCHER
LAW OFFICES

MICHAEL A. MAUCHER
MIKE@DELUCAMAUCHER.COM
(O) (843) 572-1711 • (F) (843) 572-1285
REPLY TO GOOSE CREEK OFFICE

March 7, 2019

Jason H. Highsmith, M.D.
9313 Medical Plaza Drive, Suite 305
Charleston, South Carolina 29406

RE: My Client: Scott Demaskey
Date of Accident: 12/14/18

Dear Sir or Madam:

With regard to the above-named individual, please accept this correspondence as our Law Firm's agreement to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding account balance.

With kindest regards, I am,

Very truly yours,

Michael A. Maucher

MAM/tgb
NOTE: To ensure that this office is aware of your medical lien, please provide an itemized billing statement for services rendered.

EXHIBIT E

Carolina Neurosurgery & Orthopedics, Inc.

9313 Medical Plaza, Suite 303
North Charleston, South Carolina 29406
Charleston Office: (843) 510-0727
Fax: (843) 474-0712

161 Medical Cir
West Columbia, South Carolina 29169
Columbia Office (803) 764-1813
Fax: (843) 474-0712

Health Insurance Verification Form For Surgery

MRN #:_____

Patient Name: Scott DeMaskey

DOB: [redacted] SSN: [redacted]

Insurance Company: Blue Cross Blue Shield

ID #: [redacted]

Group#: [redacted]

Please Provide a copy of your insurance card

☐ I do not have Health Insurance at this time

Scott DeMaskey — Patient Name
3-7-2019 — Date

Patient Signature

Kiara Goodwine — Witness
3/7/19 — Date

DEFENDANT'S EXHIBIT 5 5/19/23 MR HighSmith

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EXHIBIT F

Send payment to:
Carolina Neurosurgery and Orthopedics Inc.
2910 Tricom Street, Suite 201
N. Charleston
SC, 29406
Phone No : 843-510-0727 Fax : 843-474-0712

Page page 1 of 1 | Account# [redacted] | Statement Date 11/02/2020

TOTAL BALANCE: $125,409.28
(PLEASE PAY THIS AMOUNT)

Bill to:
[redacted] DEMASKEY
[redacted]E
[redacted]

Patient: [redacted] DEMASKEY [redacted]

Date	Description	Charges	Payment	Balance
	You are responsible for the following charges:			
12/20/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
09/06/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
07/18/19	POST OP	0.00	0.00	0.00
07/18/19	XRAY REVIEW	180.00	0.00	180.00
06/13/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
05/24/19	POST OP	0.00	0.00	0.00
05/02/19	[redacted] / [redacted]	62,451.87	0.00	62,451.87
04/26/19	POST OP	0.00	0.00	0.00
04/04/19	POST OP	0.00	0.00	0.00
03/15/19	[redacted]	58,697.41	0.00	58,697.41
03/07/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
01/21/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
01/21/19	XRAY REVIEW	180.00	0.00	180.00
01/21/19	[redacted]	300.00	0.00	300.00
01/21/19	[redacted]	300.00	0.00	300.00
01/02/19	NP MOD.HIGH COMPLEX	900.00	0.00	900.00
	TOTAL BALANCE ----->			$125,409.28

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EXHIBIT G

Tina

From: Tina
Sent: Friday, January 03, 2020 1:52 PM
To: 'kiara@orthoandneuro.com'
Subject: Scott DeMaskey

Kiara,

From a review of the updated itemized billing statement you recently provided, it does not appear that Blue Cross Blue Shield has paid any of your bill for services rendered. You may recall that back on:

1. December 20, 2018 we provided your office with a Letter of Protection.
2. January 21, 2019 I emailed you and requested that your office file ALL of Mr. DeMaskey's charges with BCBS due to his extensive pre-existing medical condition.
3. I thereafter emailed you advising that the at-fault party only had $30,000.00 in Liability Coverage and that Mr. DeMaskey's Underinsured Motorist Coverage does not apply.

Even though Mr. DeMaskey's medical bills total $199,744.68, there is only $30,000.00 in available coverage to pay his claim for injury. We will need to figure out a pay to spread those very limited funds around to the medical providers, our office for attorney's fees, and to Scott DeMaskey. In that regard, please confirm the balance owed on Mr. DeMaskey's account.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

DEFENDANT'S EXHIBIT 12 5/19/23 Highsmith

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EXHIBIT H

STATE OF SOUTH CAROLINA
COURT OF COMMON PLEAS
COUNTY OF CHARLESTON
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC.,
Plaintiff,
vs. CASE NO. 2021-CP-10-03379
MICHAEL A. MAUCHER, ESP. AND DELUCA & MAUCHER, LLP,

Defendants.

VIDEOCONFERENCE
DEPOSITION OF: JASON M. HIGHSMITH, MD

DATE: May 19, 2023

TIME: 3:06 PM

LOCATION: COPELAND, STAIR, VALZ & LOVELL
40 Calhoun Street
Suite 400
Charleston, SC
TAKEN BY: Counsel for the Defendants
REPORTED BY: MICHAEL DAVID ROBERTS,
Court Reporter

---

letter of protection?

A. I just don't use them. I don't use them anymore for sure probably as a result of this incident. I just don't use a letter of protection as part of my standard policy.

Q. Not anymore?

A. Not anymore, correct.

Q. Have you done it at all after Mr. Demaskey got treatment from you?

A. I don't think so. This sort of unfortunately soured it for us.

Q. And before that, how often did you provide services under a letter of protection?

A. If they came, I didn't really notice. You know, we just -- we didn't necessarily seek it out. We have a financial policy that basically says the patient is ultimately responsible for their bill.

Q. So you're not particularly worried about getting a letter of protection?

A. Correct.

Q. Prior to adopting a policy where you no longer accept letters of protection, what is it a practice to ask --

MR. WEINBERGER: Whoever is asking the

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questions, can you speak up a little bit? I'm having a hard time hearing. I don't know if I'm the only one, but if you would be kind enough to do that, I would greatly appreciate it.

THE COURT REPORTER: No, that's not it. Give me one minute.

MR. WEINBERGER: I apologize. Thank you.

(A recess transpired.)

THE WITNESS: Can you repeat the question?

BY MR. WILSON:

Q. Certainly. Let me see if I can remember it word for word. Prior to adopting a -- prior to Carolina Neurosurgery adopting a policy of no longer requesting letters of protection -- or accepting letters of protection, was it a policy to request them?

A. No, not traditionally. If they came with one, we saw -- we would see the patient either way.

Q. You would have seen the patient either way with or without a letter of protection?

A. Correct.

Q. In circumstances when you would receive

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a letter of protection, would that be documented somehow in a file outside of just putting a letter in the file for a patient?

A. That would be the only place we have it. It would just be in the chart.

Q. There's no other area where it would be marked that there's a letter of protection?

A. No, we just have it as part of the chart if it comes up.

Q. In the past for Carolina Neurosurgery, how many patients do you think you've treated best estimate under -- where a letter of protection has been involved?

A. I don't know. We don't see them very often. We never really request them, so very few.

Q. Is that just -- is that a guess? You don't really --

A. I don't really know. I don't -- we don't track that.

Q. So you wouldn't require in the past when there was a letter of protection coming in any specific type of language in that letter of protection?

A. No. Again, we don't typically request them.

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Q. So clean slate when you went over there?
A. Yes.
Q. So the intake paperwork that we've kind of discussed today, was that intake paperwork developed when you made that transfer and specific to Carolina?
A. Yes.
Q. And so from that point on -- just so we're clear -- no longer accepted insurance?
A. Correct.
Q. Unless they had something that had an out-of-network benefits that you could help the patient submit themselves to -- a claim to?
A. Correct.
Q. When you first treated Demaskey before opening Carolina, did -- do you know, were you involved at all with submitting bills to insurance during that period?
A. My office staff did that, so they were -- we were an in network at the time. We had a staff member dedicated to that.
Q. Did you take any staff members over with you to Carolina?
A. No.

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A. No, just one-sided.
Q. Is this a ledger of the services that you provided to Mr. Demaskey that are relevant to this case?
A. Yes.
Q. And the total down there it looks like it's $125,409.28; is that correct?
A. Yes.
Q. And is that amount that you -- for that -- that's at issue in this?
A. That's the entire outstanding bill, yes.
Q. And has anything been paid to date?
A. No, not to my knowledge.
Q. Now, is it those costs that you believe DeLuca & Maucher and Mike Maucher are responsible for the amount in this?
MR. PENDARVIS: Form. Objection.
THE WITNESS: Well, the patient is ultimately responsible by whatever means he can pay.
BY MR. WILSON:
Q. So do you not believe that they're responsible then?
A. I believe that the patient is

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ultimately responsible for the bill through whatever relationship he has, and I trusted the agreement we had with his attorney.

Q. All right. So the patient is ultimately responsible for the bill, and you trusted the agreement that you had with the attorney. Are you referring to the letter of protection or multiple letters of protection?

A. Yes.

Q. And is it under those letters of protection that you believe DeLuca & Maucher, Mike Maucher are responsible for their patients medical bills?

A. Under that yes, but again, ultimately the patient is responsible.

Q. Are you aware of someone pursuing coverage through OneBeacon for the surgery -- or for these medical costs?

A. I've heard that in some of the discussions with counsel, but I don't know the status of that.

Q. You don't know the status, but you're just generally aware that that might be going on?

A. Yes.

Q. And the absence of a letter of

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protection or letters of protection in this case, do you believe that DeLuca & Maucher or Mike Maucher will be responsible for Mr. Demaskey's medical bills?

A. I don't know what agreement he has with his attorneys, but again, he's ultimately responsible. And that's what we provided him the written estimates, and he signed the paperwork that he's responsible.

Q. And really what I'm trying to ask is: From your perspective I think you had testified that the letter of protection -- letter of protections -- letters of protection are the reason why DeLuca & Maucher and Mike Maucher might be responsible for the cost; is that correct?

A. That's my understanding, that they've taken on the responsibility with the letters; and again, we had no reason to doubt that was the case, and we trusted the relationship and the agreement we had.

Q. Okay. Did you have a relationship with DeLuca & Maucher or Mike Maucher prior --

A. No relationship. I meant relationship documents, the understanding, the agreement from paper.

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Q. Absent those agreements or the papers that you're referring to, do you believe that DeLuca & Maucher or Mike Maucher would be directly responsible to Carolina Neurosurgery for Mr. Demaskey's bills?

A. You said exclusive of that agreement?

Q. Yes.

A. I can't speak to that. I don't know the relationship he has with the patient. He has a relationship with me based on those documents to provide coverage.

Q. And so if those documents were not there, then would you agree that they wouldn't be responsible for direct payment to you for those medical bills or direct payment to Carolina Neurosurgery?

A. Again, I can't speak to what the patient and the attorney -- his counsel has as an agreement.

Q. Well, I'm not asking --

A. The patient is ultimately responsible.

Q. I'm not asking about their agreement or -- with their specific patient. I'm asking about any other reasons why DeLuca & Maucher or Mike Maucher could be responsible directly to you

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or directly to Carolina Neurosurgery for Mr. Demaskey's costs?

MR. PENDARVIS: Object to the form.

THE WITNESS: Again, I trust the agreement and the paperwork we had from them. Beyond that, I don't have any other way to hold them accountable.

BY MR. WILSON:

Q. Okay. Looking at exhibit 1 -- or exhibit 11, sorry, the different dates that are listed in the left-hand column, are those all dates that you would have seen Mr. Demaskey?

A. Yes, those are dates of service.

Q. Sitting here today, can you remember or recall any of the conversations that you would have had with Mr. Demaskey during these different treatments that are listed on exhibit 11?

A. Like I said, every new patient I have seen in the new practice that I had seen in the old practice I made it very clear from the very first visit everything I just mentioned before. This is a different patient interaction. I'm not in network with insurance anymore; that's why I'm not at the old practice anymore.

So that was the initial encounter with

family members refer patients. I've known other primary care docs in Charleston, so a lot of them send me patients. It just depends.

Q. Any of the intake paperwork for Carolina Neurosurgery ask how did you hear about us, anything like that?

A. It doesn't, no.

Q. All right. I'm going to hand you what's going to be marked as exhibit 1.

(DFT. EXHIBIT 1, Two-page letter to Jason H. Highsmith, MD from Michael A. Maucher dated December 20, 2018, was marked for identification.)

BY MR. WILSON:

Q. And this is a letter from DeLuca & Maucher addressed to yourself dated December of 2018. And it is front and back, but I think it's the same letter on the back, but there's, like, a fax notification at the top. Are you familiar with this document?

A. Yes.

Q. And this is the letter of protection that DeLuca & Maucher sent your office related to Mr. Demaskey's treatment; is that correct?

A. That's correct.

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Q. Do you know if you would have read this letter prior to providing any -- well, let me -- do you know if you would have read this letter prior to providing treatment on January 2nd of 2019?

A. At some point I reviewed it in his chart or in dictating his note. I don't recall exactly when.

Q. Is this something that you would have noted in any dictations for Mr. Demaskey that you read a certain document or anything like that?

A. No. Again, I'm sort of focussed on the medical with the documentation that we provide, so no.

Q. Okay. Does Kiara have the authority to accept letters of protection on behalf of Carolina Neurosurgery that you know of?

A. Well, there's a matter of accepting meaning receiving the fax and putting in the chart, yes. In terms of following through on the implementation of that, that would be something she would consult with me on.

Q. Would the practice generally be to consult with you about a letter of protection prior to providing services?

A. Not prior to providing services, but as

part of our handling of the patient, yes.

Q. So at some point afterwards yourself and Kiara would mostly have a conversation if there was a letter of protection in the file for a patient?

A. Yes, but we don't really typically use them so...

Q. All right. And the date of this letter is -- looks like December 20th, 2018; is that correct?

A. Yes.

Q. And I would like to walk you through this language real quick and get your thoughts on it. So here it begins, with regard to the above named individual. And that refers to Mr. Demaskey; is that correct?

A. Yes.

Q. And then it continues, please accept this correspondences as our law firm's agreement. The law firm would be DeLuca & Maucher; is that correct?

A. That's my understanding, yes.

Q. To protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above. And

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the incident is the accident that caused the injury necessitating the treatment you provided; is that correct?

A. That's my understanding, yes.

Q. Okay. Now, so in this letter the law firm is agreeing to protect claims out of any settlement proceeds; isn't that correct?

A. That's what it says, yes.

Q. Is that your understanding?

A. Yes.

Q. And then, I believe, it goes on to say, the above named individual. Again, that's referring to Mr. Demaskey; is that correct?

A. Yes.

Q. And then it says, in the event of insufficient recovery, he'll be responsible for the balance. Is that correct?

A. Yes.

Q. So in this letter at least there's -- it seems to be outlining a potential for -- or at least -- at least the potential for an insufficient recovery; is that correct?

A. I wouldn't say it outlines that. I mean, it certainly -- you know, we're very forthcoming with the cost to the patient and expect

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an agreement like this to be backed up by -- by adequate coverage before providing approval to do a surgery.

Q. But that's not what the letter says, is it?

A. That's not the wording, but the understanding is that the patient is being seen for treatment and the bills will be covered. Our understanding is they will stand by their word.

Q. Well, who according to this letter and your interpretation of the language of it, who's going to cover those bills?

A. Who's going to what?

Q. Who will pay -- who will cover those bills?

A. The Maucher law firm.

Q. The Maucher law firm. So then what is the point of your understanding of mentioning that the patient would be personally responsible for any account balance?

A. Because that's our policy as well. The patient is ultimately responsible.

Q. Okay. Do you know if DeLuca & Maucher was aware of the financial policy that Mr. Demaskey executed?

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A. I don't know.
Q. If I represented to you that the financial policy was executed after the date of this letter, then do you have any other independent knowledge of DeLuca & Maucher being aware of Carolina Neurosurgery's financial policy?
A. Just I provided it to them when his referral was made.
Q. When the referral was made?
A. Yeah.
Q. Well, let me hand you what's been marked as exhibit 2. This one actually matches the complaint.
(DFT. EXHIBIT 2, One-page document entitled Financial Policy, was marked for identification.)
BY MR. WILSON:
Q. Okay. Is this the financial policy that we've kind of been discussing a little bit?
A. Yes.
Q. And can you read for me the date on which it appears Mr. Demaskey signed that?
A. January 3rd, 2019.
Q. And that was really the first date according to the billing ledger that you had seen

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agrees to protect claims to settlement proceeds, correct?

A. That's what it says, yes.

Q. And then I think we got off in a little tangent here, but agree or disagree it at least mentions what will occur in the event of an insufficient recovery; is that correct?

A. Yes.

Q. Does this letter say anything about actually making payment for the claims?

A. It does not specify that.

Q. Now, if the law firm DeLuca & Maucher is holding the settlement proceeds that they have received relevant to this case, would you agree or disagree that that would be at least protecting a claim to those proceeds?

MR. PENDARVIS: Form. Objection.

THE WITNESS: I would have to defer to my counsel on that.

BY MR. WILSON:

Q. Do you know whether or not the funds are sitting in a trust account or anything like that?

A. I don't know for sure. I've heard that they may be. I don't know. Again, if something

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the primary insurance is just only if it has out-of-network benefits; is that right?

A. Correct. Like I said, we're not in network, so there's no way for us to file unless they have out-of-network benefits and there's a portal to do so.

Q. How would a staff member Kiara or Aaliyah go about determining whether or not a particular insurance card that was provided to them provided out-of-network benefits?

A. Sometimes they'll interpret it. If there's any question, then they call Eric or somebody.

Q. Other than this financial policy that the patients sign, are there any internal written policies of which you are aware that Carolina Neurosurgery has with respect to insurance?

A. No.

Q. Does Carolina Neurosurgery to your knowledge have any written policies and procedures?

A. No, just what's in our patient charts.

Q. Do you know if sitting here today at the time this financial policy was signed on January 3rd of 2019 if you would have or if you actually did review the December letter of

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protection?

A. I don't know at what point I reviewed it, but at some point in the care of Mr. Demaskey I reviewed the chart and all intake paperwork.

Q. And so that's your -- I mean, that's your standard practice is if there's any paperwork in that chart at some point in time you're reviewing everything that that patient has submitted?

A. Yes, because when the patients come to us for the initial patient visit, they have all these forms completed and I get the stack when I go talk to them.

Q. So you would have taken the stack with the financial policy, the health insurance verification form, the HIPAA notification and emergency contact information when you first saw Mr. Demaskey?

A. Yes.

Q. Is there anything in part of the patients chart or intake that indicates whether or not the patient is involved in litigation?

A. No.

Q. Is that something that you yourself are generally aware of when you treat patients?

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A. Yeah, or commute for the patient. Safer than transferring to another hospital.

Q. The surgeries that you performed on Mr. Demaskey, those were at the -- was it the Charleston Surgery Center?

A. I don't have the operative note in front of me. I don't know where they were done.

Q. Do you frequently perform surgeries at the Charleston Surgery Center?

A. Yes.

Q. Would you say that is your main location for performing elective surgery?

A. The Charleston Surgery Center is, yes.

Q. Is it exclusive for elective surgeries?

A. No, I do a lot of stuff at the hospitals still, too.

Q. Do you have any ownership interest in the Charleston Surgery Center?

A. No.

Q. Do you have any interest at all as far as like maybe a management or anything else within the Charleston Surgery Center?

A. No.

Q. So if an attorney -- looking back at exhibit 3, if an attorney or attorney's office

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doesn't know what the limits are for a particular patient, would that affect your decision to provide services?

A. I can't speak in hypotheticals.

Q. Have you ever declined to provide services in a situation where you didn't have any information about insurance coverage for potential litigation?

A. Yeah, if I don't think the patient needs surgery, I won't do surgery. Some people come in wanting surgery, and they don't need it. I'll tell them you don't need it.

Q. Did Mr. Demaskey need surgery?

A. He would -- could benefit from an elective surgery, yes. Did he need it? No. Was it life threatening? No. Was it emergent? No. It was an elective surgery. But to get relief of his pain and condition, he would need surgery.

Q. Okay. So he just needed the surgery that you performed, correct?

A. Yes.

Q. So in a situation where a patient needs surgery, and you don't know anything about what insurance coverage is, would you still provide that surgery?

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A. Yes.

Q. Do you make it a habit of concerning yourself about whether or not a patient can actually pay for your services?

A. I don't make a habit of it. I take care of the patient and trust them to pay their bills. They sign paperwork saying that I trust my patients to pay the bill.

Q. I mean, you're certainly not, like, asking any patients to show, like, bank balances or anything like that to show proof of payment or the fact that they can pay before you provide surgery; is that correct?

A. No, that's why we give them a written estimate and let them know they're responsible for the bill.

Q. Looking at exhibit 3, Tina is providing here a little bit of information about potential coverage, and in it she is saying that the at-fault party had a North Carolina policy of automobile insurance, but they were not willing to provide the limits.

So at least at this point they didn't know what -- and they meaning DeLuca & Maucher or their staff didn't know what the potential limits

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were for at least the at-fault party's insurance policy; is that correct?

MR. PENDARVIS: Objection.

THE WITNESS: That's what it says on the paperwork, but I can't speak to the validity of that statement.

BY MR. WILSON:

Q. Now, she also mentioned Mr. Demaskey's underinsured motorist coverage of $100,000; is that correct?

A. It does say that, yes.

Q. Do you know what underinsured motorist coverage is?

A. I'm not an expert in interpreting that, but my understanding is it's insurance for patients that don't have adequate -- it covers patients -- other drivers that don't have adequate insurance.

Q. And the policy would be the person who's injured?

A. That's my understanding.

Q. Do you know anything about what occupation accident coverage is?

A. Other than the title, no. I would defer to the attorneys on that.

Q. At least this email references a

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OneBeacon policy. Is that from your understanding something that someone is pursuing for Mr. Demaskey's medical costs for the services that you provided?

A. I can't speak to what's been done by them.

Q. Well, I think you testified earlier that you were generally aware something about OneBeacon; is that correct?

A. Yes.

Q. And this email does reference the OneBeacon policy?

A. Yes, it does.

Q. And do you know if you would have read this email to Kiara -- between Kiara and Tina prior to providing any services or the services after that date for Mr. Demaskey?

A. I don't know. I don't remember.

Q. Do you know if it is a part of the practice for Carolina Neuro to put emails in some type of file for the patient?

A. If it's relevant to their care, yes.

Q. Do you think that the substance of what these emails are are relevant to the care that you provided Mr. Demaskey?

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A. Again, I'm focused on the medical care, so it's not really relevant to the medical care event.

Q. Would you know if it was actually put in the file?

A. I don't know.

Q. Now, on January 21st after Tina discusses the different coverages, she notifies Kiara that she learned Mr. Demaskey required surgery. Is that your understanding of what this -- it's the first email the first page, I think.

A. What's the question?

Q. It appears to me that Tina with DeLuca & Maucher is notifying here that Mr. Demaskey will require surgery; is that correct?

A. That's what it says, yes.

Q. And it's your understanding that would have been the surgery that you performed I think it was in March of 2019?

A. Yes.

Q. And here she is at least telling Kiara that all of the treatment be filed with his private health insurance company. Is that your understanding of at least what it says?

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A. That's what it says, yes.
Q. Do you think -- and then it goes on, it would be best for everyone involved if we do not -- if we not do the treatment under an assignment, letter of protection. Is that your understanding of at least what this email says directed to Kiara?
A. That's what the email says, yes.
Q. Now, do you know if this would have triggered a conversation between Kiara and anybody else?
A. I don't know. She probably would call Eric on something like this.
Q. Okay. And then least if these -- the timing on these emails are correct, it looks like Kiara is saying, okay, thanks for the update 20 minutes later -- less than 20 minutes later; is that correct?
A. That's what -- yes.
MR. WILSON: Why don't we take just a quick five-minute break?
(A recess transpired.)
BY MR. WILSON:
Q. I'm going to hand you what's been marked as exhibit 4.
(DFT. EXHIBIT 4, Two-page email chain

commencing on Thursday, March 7, 2019 at 9:34 AM, was marked for identification.)

(Off-the-record conference.)

MR. PENDARVIS: So the exhibit is the...

(Off-the-record conference.)

BY MR. WILSON:

Q. So exhibit 4 what I've handed you appears to be -- well, the very first if you look at the email side of it is an email between Kiara and I'm assuming that's Eric Weinberger?

A. Yes.

Q. And then below that there's an email from Tina who we established is DeLuca & Maucher to Kiara about Scott Demaskey providing a different letter of protection. And she indicates in the email at least that letter of protection covers whatever is not paid by private health insurance.

Have you -- this is an exhibit. It was attached to the complaint that was filed in this case, so I'm assuming that you have seen it before?

A. Yes.

Q. Do you recall if you saw it -- do you recall when the first time you saw it was?

A. No.

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Q. And is this something that would have gone in the patient's file?

A. Maybe. It was Kiara that handled this with Eric.

Q. All right. So if we look at what the letter is that's dated March 7th, 2019 at the back, and this is another letter of protection addressed to yourself; is that correct?

A. It appears to be, yes.

Q. And it indicates, with regards to the above named individual. That is referring to Mr. Demaskey; is that correct?

A. Yes.

Q. It says, please accept this correspondence as our law firm's agreement to protect any portion of bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above. And the law firm is DeLuca & Maucher, correct?

A. Yes.

Q. Incident above is the vehicle accident that Mr. Demaskey was in; is that correct?

A. Yes.

Q. Now, here again, the agreement is to

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protect any portion of the bill not paid by private -- at least here it's now introducing private health insurance, but again, we're looking at an agreement to protect bills out of settlement proceeds; is that correct?

MR. PENDARVIS: Objection.

Answer if you can.

THE WITNESS: That's what it appears to be, yeah. Unfortunately, yeah, but it wasn't the case.

BY MR. WILSON:

Q. And this is -- I mean, it's similar to the first letter of protection that we went over already; is that correct?

A. Similar wording, yes.

Q. Except that it talks about private health insurance; is that correct?

A. Yes.

Q. And Carolina Neurosurgery's practice is that it doesn't accept private health insurance, is that correct, unless it's out-of-network benefits?

A. Correct.

Q. And, again, this is indicating that the individual, referring to Mr. Demaskey, has informed in the event of an insufficient recovery he would

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be responsible; is that accurate?

A. Yes. Unfortunately he's going to go bankrupt for this.

Q. And nothing in this letter indicates that law firm would pay for the medical bills in the event that there's insufficient recovery; is that correct?

A. It doesn't state that, correct.

Q. Now, did you have any conversation that you can recall with Kiara about this letter of protection?

A. No.

Q. Do you know if you would have reviewed this letter before giving -- before performing the surgery that was in March of 2019 for Mr. Demaskey?

A. Again, I reviewed the chart, so at some point I would have reviewed it. I don't recall exactly when.

Q. Let me show you what's been marked as exhibit 5.

(DFT. EXHIBIT 5, One-page document entitled Health Insurance Verification Form For Surgery, was marked for identification.)

BY MR. WILSON:

Q. We discussed the health insurance

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verification form previously. Is that what this documents appears to be?

A. Yes.

Q. Are patients only required to fill out a health insurance verification form prior to surgery, or do they also do something like that at intake?

A. They do a similar form at intake.

Q. And that form would most likely be in the patient's file?

A. Yes.

Q. Do you know if Kiara -- at least looking at this document it appears Kiara Goodwine has written her name as a witness?

A. Yes.

Q. Do you recognize her -- that as her handwriting?

A. Yes.

Q. Okay. And this is part of the practice for Carolina Neurosurgery prior to providing any surgery; is that correct?

A. Well, if the patients complete the paperwork, yes.

Q. And at least for this one this is specific for surgery, correct -- in anticipation of

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surgery?
A. That's correct.
Q. And at least on this form it looks like Mr. Demaskey has provided his insurance company's name and ID number and group number; is that correct?
A. At this time he did, yes. Before he said he didn't have health insurance so...
Q. Before this document he said he didn't have health insurance?
A. I'm not sure at what point he said he didn't have health insurance. I don't have the whole chart here but...
Q. So at least at this point he's saying he did have health insurance?
A. At this point he did.
Q. Okay. Now, is it part of either Carolina Neurosurgery's practice or Kiara's practice to highlight specific sections on forms that clients need to complete?
A. Well, they're supposed to complete the whole form, but sometimes people don't, so we highlight the most important parts.
Q. Highlight the most important parts?
A. (Witness moves head up and down.)

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THE COURT REPORTER: Can we go off real quick?

MR. WILSON: Yeah.

(Off-the-record conference.)

BY MR. WILSON:

Q. Just a housekeeping thing. You've checked your phone a couple of times during this deposition. You're not getting any kind of texts about the substance of your testimony during this deposition, are you?

A. No, I'm trying to keep in touch with my wife to see if she can pick up our son. I would like to get this done.

Q. All right. If you could compare this to exhibit 11, it appears that you provided services to Mr. Demaskey on March 7th, 2019, the date that this document is executed; is that correct?

A. Yes.

Q. And that would have been the first surgery if you look at exhibit 11, March 15th, 2019?

A. Yes.

Q. So then prior to the first surgery Mr. Demaskey has provided information about his

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insurance provider to your office; is that correct?
A. It appears to be, yes.
Q. Now, for Blue Cross Blue Shield, are there any versions of their policies that have out-of-network benefits that your -- that Carolina Neurosurgery would bill to?
A. If they have out-of-network benefits, we bill for out-of-network benefits, but we also submit this information to the surgery center because they are in network.
Q. The surgery center is in network for Blue Cross?
A. Correct.
Q. And how do you know that?
A. Just because they ask for this information if you're a network provider for them.
THE COURT REPORTER: It looks like the Zoom disconnected.
(Off-the-record conference.)
BY MR. WILSON:
Q. Does the surgery center and Charleston Surgery Center have a different business name?
A. It's the Charleston Surgery Center, and there's different -- there's other surgery centers in Charleston. There's the Charleston Surgery

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is that accurate?

A. Yes.

Q. Okay. Would your office have already maintained, to your knowledge, Mr. Demaskey's Blue Cross Blue Shield insurance information?

A. I don't know. If the card is no good and the policy is expired, we may not. I don't know.

Q. Do you know if by this point Mr. Demaskey's Blue Cross Blue Shield policy was expired?

A. I don't know.

Q. And your office never actually tried to submit any bills to Blue Cross Blue Shield; is that correct?

A. My understanding was he had no out-of-network benefits, so there was nothing we could help him with.

Q. And that was your understanding at the time of each treatment that you provided him?

A. Yes.

Q. And that would have been a conversation that you had with Kiara?

A. Yes, and again with the patient as well.

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would this have been the first notification to Kiara or Carolina Neuro about the at-fault party's coverage amount?

A. That's -- to my knowledge that is, yes.

Q. And then also that the underinsured motorist coverage does not apply, correct?

A. Correct. Yeah, it's unfortunate at this point. He's due a lot of bills.

Q. And in this last paragraph that she's sending to Kiara she's referencing the need to spread around the settlement proceeds that they received to the various different providers to cover portions of the medical bills; is that accurate?

A. Yes.

Q. And in Carolina Neurosurgery's past has there ever been a situation that you can recall where treatment has been provided where the coverage and settlement is insufficient to cover your bills and Carolina has agreed to waive costs or some other form of reducing the bill?

A. Certainly on a case-by-case basis we have, but again, my understanding is there was coverage there. We had a relationship with the attorney through the letters that, you know, this

is egregious that he would have only $30,000 in coverage and they would approve not one but two surgeries. It's unbelievable to me.

Q. Well, now, did DeLuca & Maucher approve the surgeries?

A. Well, they provided coverage and agreement that they would cover the bills based on the letters of protection.

Q. Well, the letters of protection said that they would protect claims of settlement proceeds; isn't that correct?

A. It stipulates that, but I mean the fact that they don't know the coverage and promised a one million dollar policy early on but never -- never came to fruition.

Q. And correct me if I'm wrong, but I believe you testified earlier that the amount of coverage doesn't necessarily affect your treatment recommendation; is that accurate?

A. It doesn't affect my treatment recommendations, no; but if it's an elective surgery, I'm not going to put someone through a huge bill if there's supposed coverage that doesn't exist --

Q. And then at least --

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A. -- unless it's emergent.
Q. Sorry. And at least in Mr. Demaskey's case his surgery was elective, but you testified that he did need it; is that correct?
A. Yes. It was medically necessary.
Q. I'm going to hand you what's been marked as exhibit 13.
(DFT. EXHIBIT 13, Multipage letter to Scott Demaskey from Blue Cross Blue Shield dated August 26, 2021, was marked for identification.)
BY MR. WILSON:
Q. Other than potentially reviewing this five-page document before this deposition and the exhibits that we sent previously, do you recall any independent knowledge of seeing this document before?
A. No.
Q. No. Okay. Do you have any knowledge of whether or not Mr. Demaskey's Blue Cross Blue Shield insurance was active during all the treatment that you provided without getting into whether or not he had out-of-network benefits?
A. I don't know. I would point to if his policy was valid or what coverage dates he had.
Q. And if I represent to you at least his

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PENDARVIS LAW OFFICES, PC

EXHIBIT
I

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September 27, 2022

VIA EMAIL ONLY

Douglas W. MacKelcan, Esq.
COPELAND, STAIR, VALZ & LOVELL, LLP
dmackelcan@csvl.law

Michael C. Masciale, Esq.
COPELAND, STAIR, VALZ & LOVELL, LLP
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Re: CAROLINA NEUROSURGERY & ORTHOPEDICS, INC. vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP

Dear Mr. MacKelcan and Mr. Masciale:

Enclosed, please find for service upon you, PLAINTIFF'S ANSWERS TO DEFENDANTS' FIRST SET OF INTERROGATORIES and PLAINTIFF'S RESPONSES TO THE DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION; together with a CERTIFICATE OF SERVICE. The documents in response have been uploaded to OneDrive and a link to that folder is being provided below.

https://pendarvislaw-my.sharepoint.com/:f:/p/tracy/EtUFgRvYrrBPvMMXgdbAf_YBMhoVW9mWkKMJMEWcKxX4AQ?e=TKCdq0

With kind regards, I remain

Sincerely,

PENDARVIS LAW OFFICES, P.C.

Tracy Lynn Landry

Tracy Lynn Landry

Enclosures
ec: Jason M. Highsmith, M.D.
Eric Weinberger

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STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, Defendants.	**PLAINTIFF'S ANSWERS TO DEFENDANTS' FIRST SET OF INTERROGATORIES TO PLAINTIFF**

TO: DOUGLAS W. MACKELCAN, ESQ. AND MICHAEL C. MASCIALE, ESQ., COUNSEL FOR DEFENDANTS:

Pursuant to Rule 33 of the South Carolina Rules of Civil Procedure, Plaintiff responds to Defendants' First Set of Interrogatories to Plaintiff, dated August 11, 2022, as follows.

ANSWERS TO INTERROGATORIES

INTERROGATORY NO. 1: State the names and addresses of persons known to the parties or counsel to be witnesses concerning the facts of the case and indicate whether or not written or recorded statements have been taken from the witnesses, and if so, indicate who has possession of such statements.

ANSWER: Plaintiff identifies the individuals listed on Exhibit 1, and the presumptive Rule 30(b)(6), SCRCP, designees of the organizations listed on Exhibit 2. Unless otherwise indicated, Plaintiff is unaware of any written or recorded statements. The section identified as "Role in Case" provides the information known about each witness and includes a summary to inform the other party of the important facts known to or observed by such witness.

INTERROGATORY NO. 2: For each person known to the parties or counsel to be a witness concerning the facts of this case, set forth either a summary sufficient to inform Defendant of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witness.

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ANSWER: **See Answer to Interrogatory No. 1.**

INTERROGATORY NO. 3: Set forth a list of photographs, plats, sketches, or other prepared documents in the possession, custody, or control of Plaintiff or its counsel that relate to the claims or defenses in this case.

ANSWER: **Plaintiff identifies the documents listed on Exhibit 3 and produced contemporaneously herewith in response to Request for Production.**

INTERROGATORY NO. 4: Identify each and every witness whom Plaintiff expects to call as a witness at the trial of this case.

ANSWER: **Plaintiff has not identified any witnesses Plaintiff expects to call as a witness at the trial of this case. Plaintiff proposes the parties exchange witness lists prior to the trial of this lawsuit.**

INTERROGATORY NO. 5: Set forth an itemized statement of all damages claimed to have been sustained by Plaintiff as a result of the matters alleged in the Complaint.

ANSWER: **Objection. Plaintiff is not able to fully and accurately respond to this interrogatory at this time. Plaintiff reserves the right to produce itemized statement in the future and will timely supplement its interrogatory responses accordingly.**

INTERROGATORY NO. 6: List the name and address of any expert witnesses whom Plaintiff proposes to use as a witness at the trial of this case.

ANSWER: **Plaintiff has not identified an expert witness, reserves the right name expert witness in the future, and will timely supplement its interrogatory responses accordingly.**

INTERROGATORY NO. 7: For each expert witness whom Plaintiff proposes to use as a witness at the trial of this case, please set forth:

a. the subject matter on which the expert is expected to testify;

b. the substance of the facts and opinions to which the expert is expected to testify;

c. a summary of the grounds for each opinion;

d. a complete list of articles, treatises, texts, technical bulletins, professional

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guidelines, periodicals or papers which support the expert's opinion. For each text or periodical cited, please denote the chapter and page where the information is located that supports the expert's opinion;

e. whether the witness has testified in any breach of contract or Unfair Trade Practices Act cases before and, if so, please list each time the witness has testified, including the name of the court and whether the witness testified for the plaintiff or the defendant;

f. whether the witness, in any prior testimony in a breach of contract or Unfair Trade Practices Act case, was paid compensation for his or her testimony and, if so, for each act of testimony, the amount of compensation paid and by whom; and

g. whether the witness served as an expert witness and testified in any prior case involving Plaintiff's attorney or any other member of the firm of the attorneys for Plaintiff and, if so, state the name and the action in which the testimony was given, the amount of compensation paid to the witness, and the source of the compensation of the witness.

ANSWER: **See Answer to Interrogatory No. 6.**

INTERROGATORY NO. 8: Identify each and every communication between Plaintiff and/or its counsel and Defendants, their agents, and/or employees relating to the matters set forth in Plaintiff's Complaint. In responding, please set forth: (1) the date of the communication; (2) the parties to the communication; (3) the mode of communication; and (4) a summary of its substance.

ANSWER: **Plaintiff identifies documents contemporaneously produced in Plaintiff's responses to Request for Production, which documents are provided via OneDrive link and Bates Labeled as: JH_00001-00177; JM_00001; and BS_00001-00649. In response to subparts (1) – (4), and under Rule 33(c), SCRCP, the answer to these subparts may be derived or ascertained from the documents produced, JH_00001-00177; JM_00001; and BS_00001-00649.**

INTERROGATORY NO. 9: Identify each and every communication between Plaintiff and/or its counsel and any third parties relating to the matters set forth in Plaintiff's

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Complaint. In responding, please set forth: (1) the date of the communication; (2) the parties to the communication; (3) the mode of communication; and (4) a summary of its substance.

ANSWER: **Objection. The information responsive to this request is protected from production under the client-lawyer privilege and all protections under Rule 26(b)(3), SCRCP, and the work product doctrine regarding all such communications. Plaintiff's representative and its undersigned counsel representing Plaintiff in this lawsuit have communicated with counsel for Plaintiff in the related case involving Mr. Demaskey. Plaintiff's representative, its undersigned counsel representing Plaintiff in this lawsuit, and counsel for Plaintiff in the related case involving Mr. Demaskey are and have been operating under a Joint Defense Agreement to preserve all client-lawyer privilege and all protections under Rule 26(b)(3), SCRCP, and the work product doctrine regarding all such communications.**

INTERROGATORY NO. 10: Identify with specificity any and all contracts for services, agreements for use of surgical facilities, operating room schedules, and other documents between Plaintiff and/or Jason Highsmith, M.D. and the Center for Advanced Surgery, LLC.

ANSWER: **Plaintiff no longer has ownership and currently has only privileges to practice at the Center for Advanced Surgery.**

INTERROGATORY NO. 11: Set forth whether Jason Highsmith, M.D. possesses any ownership or management interest, or any other legal or equitable interest, in the Center for Advanced Surgery, LLC. If so, please set forth the nature and percentage of his interest and the date such interest was acquired.

ANSWER: **None**.

INTERROGATORY NO. 12: Set forth whether Plaintiff possesses any ownership or management interest, or any other legal or equitable interest, in the Center for Advanced Surgery, LLC. If so, please set forth the nature and percentage of its interest and the date such interest was acquired.

ANSWER: **None.**

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INTERROGATORY NO. 13: Set forth whether any entity associated with Plaintiff and/or Jason Highsmith, M.D. possesses any ownership or management interest, or any other legal or equitable interest, in the Center for Advanced Surgery, LLC. If so, please set forth the nature and percentage of its interest and the date such interest was acquired.

ANSWER: **None.**

INTERROGATORY NO. 14: Identify with specificity any and all policies or procedures relating to the submission of proposed surgical procedures to a patient's health insurance provider for "pre- approval" which Plaintiff has had in place since 2018.

ANSWER: **None.**

INTERROGATORY NO. 15: Identify with specificity any and all policies or procedures relating to the submission of claims for medical and/or surgical services to a patient's health insurance provider for payment which Plaintiff has had in place since 2018.

ANSWER: **None.**

INTERROGATORY NO. 16: Identify with specificity any and all policies or procedures relating to the investigation and/or determination of Plaintiff and/or Jason Highsmith, M.D.'s "in-network" or "out-of-network" status with regard to health insurance providers, which Plaintiff has had in place since 2018.

ANSWER: **Plaintiff and Jason Highsmith, M.D. have been "Out of Network" since 2018.**

INTERROGATORY NO. 17: Identify with specificity any and all medical or surgical services rendered by Plaintiff or Jason Highsmith, M.D. to Scott DeMaskey prior to December 14, 2018. In responding, please identify: (1) the date(s) of such prior services; (2) a description of the services rendered; (3) any insurance claim information relating to such services; and (4) any payments received by Plaintiff and/or Jason Highsmith, M.D. for such services.

ANSWER: **Objection. This interrogatory is not reasonably calculated to lead to discovery of evidence admissible at trial of this case. In addition, Plaintiff and/or Jason Highsmith, M.D. no longer has the information responsive to this request as this Interrogatory seeks**

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information related to events over the retention policy of 7 years.

INTERROGATORY NO. 18: Set forth each and every attempt Plaintiff, Jason Highsmith, M.D., and/or their agents or employees made to determine the existence and availability of health insurance for Scott DeMaskey during 2018-2020. In responding, please provide: (1) the date of each attempt; (2) a description of what was undertaken; and (3) the result of each attempt.

ANSWER: Mr. DeMaskey advised Jason Highsmith, M.D. in writing that he had health insurance for his first surgery; however, Mr. DeMaskey was unable to pay for the co-pays or deductibles. Mr. DeMaskey advised Jason Highsmith, M.D. that he did not health insurance for his second surgery.

INTERROGATORY NO. 19: Set forth each and every attempt Plaintiff, Jason Highsmith, M.D., and/or their agents or employees made to determine the existence and availability of liability insurance, or any other insurance, for Scott DeMaskey during 2018-2020. In responding, please provide: (1) the date of each attempt; (2) a description of what was undertaken; and (3) the result of each attempt.

ANSWER: In response to subparts (1) – (3), and under Rule 33(c), SCRCP, the answer to these subparts may be derived or ascertained from the documents contemporaneously produced in Plaintiff's responses to Request for Production, which documents are provided via OneDrive link and Bates Labeled as: JH_00105-00159; BS_00046-00047; BS_00060-00071; BS_00074-00076; BS_00084-00108; BS_00110-00135; BS_00348-BS_370.

INTERROGATORY NO. 20: Identify all actions taken by Plaintiff and/or Jason Highsmith, M.D. to seek payment, from any source, for the medical and surgical services rendered to Scott DeMaskey which are the subject of this case. In responding, please provide: (1) the date of each action; (2) a description of what was undertaken; and (3) the result of each action.

ANSWER: In response to subparts (1) – (3), and under Rule 33(c), SCRCP, the answer to these subparts may be derived or ascertained from the documents contemporaneously

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produced in Plaintiff's responses to Request for Production, which documents are provided via OneDrive link and Bates Labeled as: JH_00001-00177; and BS_00001-00649.

INTERROGATORY NO. 21: Identify with specificity the basis for Plaintiff's belief that it is entitled to recover "all fees and costs generated in pursue *[sic]* of the relief claimed, including but not limited to legal fees", under the March 7, 2019 Letter of Protection, as alleged in Paragraph 45 of the Complaint.

ANSWER: **In Defendants' letters of protection dated December 28, 2018 and March 7, 2019, Defendants promised to "protect any claim" and "protect any portion of your bill not paid by private health insurance." In common English, Plaintiff understood the "protection" Defendants promised included legal fees incurred in obtaining the recovery Defendants' promise to protect.**

INTERROGATORY NO. 22: Identify with specificity the basis for Plaintiff's belief that Defendants' alleged conduct in this case was "unfair or deceptive", as set forth in Paragraph 49 of the Complaint.

ANSWER: **It is simply "unfair or deceptive" for a lawyer and a law firm to make representations, assurances, and promises to a healthcare provider that payments for elective surgical procedures to be rendered by the healthcare provider to the lawyer's client would be paid out of $1,100,000 of liability coverage available to the at-fault party who allegedly injured the lawyer's client when the lawyer and law firm did not verify the availability of the insurance coverage before making the representations to the healthcare provider. Defendants' unfair or deceptive practices are highlighted by Defendants' knowledge that Plaintiff was an out-of-network healthcare provider regarding the lawyer's client's insurance coverage.**

INTERROGATORY NO. 23: Identify with specificity the basis for Plaintiff's belief that Defendants' alleged unfair or deceptive conduct in this case was "willful", as alleged in Paragraph 49 of the Complaint.

ANSWER: **See Answer to Interrogatory No 22.**

INTERROGATORY NO. 24: Identify any litigation to which Plaintiff and/or Jason

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Highsmith, M.D. have been a party within the last five (5) years. In responding, please provide: (1) the case number and caption; (2) type of case; (3) venue; and (4) outcome of the case.

ANSWER: **Objection. This interrogatory is not reasonably calculated to lead to discovery of evidence admissible at trial of this case.**

INTERROGATORY NO. 25: Identify with specificity any and all policies or procedures relating to the collection of debts owed for medical and/or surgical services, which Plaintiff and/or Jason Highsmith, M.D. have had in place since 2015.

ANSWER: **This matter is the first for Jason Highsmith, M.D. and Plaintiff.**

INTERROGATORY NO. 26: Set forth Plaintiff's annual income for each year since 2018.

ANSWER: **Objection. This interrogatory is not reasonably calculated to lead to discovery of evidence admissible at trial of this case.**

INTERROGATORY NO. 27: Set forth Jason Highsmith, M.D.'s annual income for each year since 2018.

ANSWER: **Objection. This interrogatory is not reasonably calculated to lead to discovery of evidence admissible at trial of this case.**

Respectfully submitted,

/s/ Thomas A. Pendarvis
Thomas A. Pendarvis (SC Bar # 064918)
Christopher W. Lempesis, Jr. (SC Bar # 77012)
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September 27, 2022

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STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, Defendants.	**PLAINTIFF'S RESPONSES TO DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION TO PLAINTIFF**

TO: DOUGLAS W. MACKELCAN, ESQ. AND MICHAEL C. MASCIALE, ESQ., COUNSEL FOR DEFENDANTS

Pursuant to Rule 34 of the South Carolina Rules of Civil Procedure, Plaintiff responds to Defendants' First Set of Requests for Production to Plaintiff, dated August 11, 2022, as follows.

GENERAL RESPONSES TO REQUESTS FOR PRODUCTION

Plaintiff does not intend to produce or specifically identify documents already received from Defendants, whether in discovery in this case or prior to the filing of this lawsuit. Plaintiff likewise does not intend to produce or specifically identify documents received by Defendants by virtue of a subpoena issued by counsel for Defendants. Please notify Plaintiff's counsel if Defense Counsel objects to this General Response.

RESPONSES TO REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 1: A copy of all documents, electronically stored information, writings, drawings, graphs, charts, photographs, recordings, other data compilations, or any tangible items relating to the events or occurrences forming the basis of Plaintiff's claims or otherwise related to the allegations set forth in the Complaint.

RESPONSE: Plaintiff identifies documents previously provided or produced to Plaintiffs by Defendants or their counsel, and documents contemporaneously produced via OneDrive link and Bates Labeled as: JH_00001-00177; JM_00001; and BS_00001-00649.

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REQUEST FOR PRODUCTION NO. 2: A copy of all statements, whether written, recorded, or otherwise, obtained from any party or witness.

RESPONSE: See response to Request for Production No. 1.

REQUEST FOR PRODUCTION NO. 3: A copy of all documents, statements, reports, or other materials referred to or relied upon to formulate Plaintiff's responses to Defendants' First Set of Interrogatories served contemporaneously herewith.

RESPONSE: See response to Request for Production No. 1.

REQUEST FOR PRODUCTION NO. 4: A copy of all documents or other tangible items Plaintiff intends to introduce as an exhibit or otherwise rely upon at the trial of this lawsuit.

RESPONSE: See response to Request for Production No. 1.

REQUEST FOR PRODUCTION NO. 5: A copy of all correspondence, whether written or electronic, between Plaintiff, Jason Highsmith, M.D., or Plaintiff's counsel and any third-party regarding the matters set forth in the Complaint.

RESPONSE: Objection. The documents responsive to this request are protected from production under the client-lawyer privilege and all protections under Rule 26(b)(3), SCRCP, and the work product doctrine regarding all such communications. Plaintiff's representative and its undersigned counsel representing Plaintiff in this lawsuit have communicated with counsel for Plaintiff in the related case involving Mr. Demaskey. Plaintiff's representative, its undersigned counsel representing Plaintiff in this lawsuit, and counsel for Plaintiff in the related case involving Mr. Demaskey are and have been operating under a Joint Defense Agreement to preserve all client-lawyer privilege and all protections under Rule 26(b)(3), SCRCP, and the work product doctrine regarding all such communications.

REQUEST FOR PRODUCTION NO. 6: A copy of all correspondence, whether written or electronic, between Plaintiff, Jason Highsmith, M.D., or Plaintiff's counsel and Scott DeMaskey regarding the matters set forth in the Complaint.

RESPONSE: Plaintiff identifies documents contemporaneously produced via OneDrive link and Bates Labeled as: JH_00001-00177.

REQUEST FOR PRODUCTION NO. 7: A copy of all correspondence, whether written or

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electronic, between Plaintiff, Jason Highsmith, M.D., or Plaintiff's counsel and Defendants, or their employees and/or agents, regarding the matters set forth in the Complaint.

RESPONSE: **Objection. The documents responsive to this request are protected from production under the client-lawyer privilege and all protections under Rule 26(b)(3), SCRCP, and the work product doctrine regarding all such communications. Plaintiff's representative and its undersigned counsel representing Plaintiff in this lawsuit have communicated with counsel for Plaintiff in the related case involving Mr. Demaskey. Plaintiff's representative, its undersigned counsel representing Plaintiff in this lawsuit, and counsel for Plaintiff in the related case involving Mr. Demaskey are and have been operating under a Joint Defense Agreement to preserve all client-lawyer privilege and all protections under Rule 26(b)(3), SCRCP, and the work product doctrine regarding all such communications.**

REQUEST FOR PRODUCTION NO. 8: A copy of all correspondence, whether written or electronic, that was generated, sent, or received by any agents and/or employees of Plaintiff-including but not limited to Kiara Goodwine-regarding the matters set forth in the Complaint. This request includes any emails on which any of Plaintiff's agents and/or employees were "cc'd" or "bcc'd."

RESPONSE: **See response to Request for Production No. 1.**

REQUEST FOR PRODUCTION NO. 9: A copy of any and all documents evidencing any damages claimed by Plaintiff in this action.

RESPONSE: **Plaintiff is not able to fully and accurately respond to this request at this time. Plaintiff reserves the right to produce documents evidencing damages in the future and will timely supplement its responses accordingly.**

REQUEST FOR PRODUCTION NO. 10: A copy of any and all policies or procedures relating to the submission of proposed surgical procedures to a patient's health insurance provider for "pre-approval" which Plaintiff has had in place since 2018.

RESPONSE: **None.**

REQUEST FOR PRODUCTION NO. 11: A copy of any and all policies or procedures relating

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to the submission of claims for medical and/or surgical services to a patient's health insurance provider for payment which Plaintiff has had in place since 2018.

RESPONSE: None.

REQUEST FOR PRODUCTION NO. 12: A copy of any and all policies or procedures relating to the investigation and/or determination of Plaintiff's and/or Jason Highsmith, M.D.'s "in-network" or "out-of-network" status with regard to health insurance providers, which Plaintiff has had in place since 2018.

RESPONSE: None.

REQUEST FOR PRODUCTION NO. 13: A copy of any and all administrative documentation relating to any medical and/or surgical services rendered to Scott DeMaskey prior to December 14, 2018. This request includes any insurance claim documents or correspondence, and any documents evidencing payment, from whatever source, for such medical and/or surgical services.

RESPONSE: Plaintiff identifies documents contemporaneously produced via OneDrive link and Bates Labeled as: JH_00001-00177.

REQUEST FOR PRODUCTION NO. 14: A copy of Plaintiff's federal and state income tax returns, and all schedules attached thereto, for tax years 2018-2021.

RESPONSE: Objection. This document production request is not reasonably calculated to lead to discovery of evidence admissible at trial of this case.

REQUEST FOR PRODUCTION NO. 15: A copy of any and all employee training manuals, handbooks, or policies which Plaintiff has had in place or otherwise utilized since 2017.

RESPONSE: Objection. This document production request is not reasonably calculated to lead to discovery of evidence admissible at trial of this case.

REQUEST FOR PRODUCTION NO. 16: A copy of any personnel files which Plaintiff maintains, or which are maintained on behalf of Plaintiff, for any employees and/or agents of Plaintiff who were involved in the matters underlying this action. This request includes, but is not limited to, any such files for Kiara Goodwine and Jason Highsmith, M.D.

RESPONSE: Objection. This document production request is not reasonably calculated to lead to discovery of evidence admissible at trial of this case

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REQUEST FOR PRODUCTION NO. 17: A copy of the Articles of Incorporation for Carolina Neurosurgery & Orthopedics, Inc. and any amendments thereto.

RESPONSE: Objection. This document production request is not reasonably calculated to lead to discovery of evidence admissible at trial of this case.

REQUEST FOR PRODUCTION NO. 18: A copy of the Bylaws for Carolina Neurosurgery & Orthopedics, Inc. and any amendments thereto.

RESPONSE: Objection. This document production request is not reasonably calculated to lead to discovery of evidence admissible at trial of this case.

REQUEST FOR PRODUCTION NO. 19: A copy of the Articles of Organization for the Center for Advanced Surgery, LLC and any amendments thereto.

RESPONSE: Objection. This document production request is not reasonably calculated to lead to discovery of evidence admissible at trial of this case.

Respectfully submitted

/s/ Thomas A. Pendarvis
Thomas A. Pendarvis (SC Bar # 064918)
Christopher W. Lempesis, Jr. (SC Bar # 77012)
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Beaufort, South Carolina

September 27, 2022

ELECTRONICALLY FILED - 2024 Aug 14 12:40 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

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STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, Defendants.	**CERTIFICATE OF SERVICE**

I, Tracy Lyn Landry, paralegal for Pendarvis Law Offices, P.C., hereby certify that I have served the documents listed below upon all counsel of record by **email only**, to said counsel at the following email address(s):

Douglas W. Mackelcan, Esq.
COPELAND, STAIR, VALZ & LOVELL, LLP
dmackelcan@csvl.law

Michael C. Masciale, Esq.
COPELAND, STAIR, VALZ & LOVELL, LLP
mmasciale@csvl.law

Documents Served:

- PLAINTIFF'S RESPONSES TO DEFENDANTS' FIRST SET OF INTERROGATORIES TO PLAINTIFF; AND
- PLAINTIFF'S RESPONSES TO DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION TO PLAINTIFF.

Tracy Lyn Landry

September 27, 2022

Beaufort, South Carolina

EXHIBIT J

STATE OF SOUTH CAROLINA	) COURT OF COMMON PLEAS
	) NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	) CASE NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC.,	)
PLAINTIFF,	)
-VS-	)
MICHAEL A. MAUCHER, ESQ. and DeLUCA & MAUCHER, LLP,	)
DEFENDANTS.	)

CERTIFIED TRANSCRIPT

VIDEOTAPED

30(b)(6)

DEPOSITION OF:

DeLUCA & MAUCHER, LLP

MICHAEL A. MAUCHER

JULY 31, 2023

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letter, perhaps it was a letter. I don't know if it was an e-mail or a letter, but e-mails or letters of the type I guess from Jay Masty to you providing essentially all the documents that have been discussed and that are relevant to this case; I did see that. But again, that e-mail just had documents that were discussed in Ms. Bennett's deposition in detail.

So getting back to the next question, we're looking at Number 30(b)(6) Topic No. 3?

Q Correct?

A 16?

Q About the allegations in Paragraph 16, the complaint --

A That's denied.

Q -- and the responses to 16 and the answer.

A That's right.

Q All right.

A All right. So at this time, I don't understand what that means, at the time that the interrogatory's propounded at the time that we first started to see -- to represent Mr. DeMaskey. You can't admit something that you don't understand.

But moving on: It says based on representations of the lawyers in the first Letter of Protection. Let's be really clear: Mr. DeMaskey went

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to Dr. Highsmith because he had an established relationship with Dr. Highsmith because he had performed surgery on him in the past.

We didn't -- we, anytime I say "we," refers to D&M. We didn't send DeMaskey to Dr. Highsmith. So I'm real confused by that. That Letter of Protection wasn't bargained for between Dr. Highsmith and our office. Mr. DeMaskey had a conversation with someone at Carolina Neurosurgery, and he advised my assistant, Tina Bennett, to send Dr. Highsmith a Letter of Protection, which we did. That Letter of Protection speaks for itself.

And moving on: And I think this contention in Paragraph 16 discusses a bunch of different topics, another reason to deny it.

However, it's my recollection that initially we were advised by the insurance company for the owner of the car in North Carolina that Mr. DeMaskey was involved in a wreck. We were advised initially that the car was stolen. And as you know, as an esteemed and knowledgeable attorney, if a car is stolen, then you have to use your uninsured motorist coverage. Uninsured motorist coverage I believe on the tractor or the truck Mr. DeMaskey was operating was a million dollars.

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I think, at that time, Mr. DeMaskey had $100,000 underinsured motorist policy, and we didn't know if that paid -- would cover or would not cover. So early on, this is an accurate statement about the possible 1,100,000, but as time went on, for whatever reason, the insurance company, the owner accepted liability coverage, which reduced the policy to $30,000, at which point we let everybody know. We told Dr. Highsmith's office to proceed under Bluecross/Blueshield, which led to a second Letter of Protection, which was merely a Letter of Protection for anything not paid by health insurance. So I think that's why Paragraph 16 is denied.

Q Let's take a look at some of the -- let's put in context. The paragraph before references the financial policy of Carolina Neurosurgery. And the other arrangement phrase in that paragraph we just discussed under the earlier topic was the policy requires full payment unless other arrangements have been made. Okay? Context.

So the other arrangements we're talking about, I think you've just described, insurance coverage and some other things that were being considered, correct? At the time -- before the first surgery.

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A So you just said a lot. And a couple of different things. I'm trying to follow. Let's be very clear: What occurred between Mr. DeMaskey and Carolina Neurosurgery, we didn't have anything to do with that. He just went there as a patient. So you can't attribute to me Mr. DeMaskey and Carolina -- or DeLuca & Maucher to DeMaskey and Carolina Neurosurgery. I just did what my client asked me: I sent a Letter of Protection. Once things changed, I let everybody know.

Q Let's take a look at Exhibit 4 to the -- Exhibit 4 to Exhibit 2 for this deposition; that's the complaint. Take a look at Exhibit 4 to the complaint, and I want to take you to Page 2 of Exhibit 4.

A (Complies.)

Q The very first page of Exhibit 4 to the complaint, at the top of that page is a January 21, 2019 e-mail. I want to take you to the page before that. I mean, the page behind that. Sorry.

A Yeah, if you're trying to confuse me, you're doing a good job. All right. So this is still early, very early, a month after the wreck, and this is our communication to Kiara, who's I think the office manager or someone in authority at Carolina Neurosurgery, to file Bluecross/Blueshield.

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enough overall coverage to pay the claim."

A You read it correctly.

Q What -- what was the basis for that statement?

A That's -- that was our opinion at that time. Of course, that changed. And as soon as it changed, we let Dr. Highsmith's office know.

Q Was that after the first surgery or after the second surgery?

A It was before the first surgery, sir; you know that. You know these -- why would you try to put words in my mouth like that?

Q I'm asking.

A You know the answer. So why would you misstate -- why would you phrase a question that purposely is confusing trying to trick the witness? I'm here to answer all your questions, but you know that before the first surgery. I think there may be $2,600 in treatment at the point we said, "Hey, use his Bluecross/Blueshield." They should have done that. So I won't put words in your mouth if you don't try to put words in my mouth.

Q Did D&M look into whether the Carolina Neurosurgery was in-network or not and whether it would be available for the Bluecross/Blueshield policy

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for their services to be used?

A We didn't know anything. I already said this. We didn't know anything between DeMaskey and Highsmith. He went to Dr. Highsmith, and they didn't send us a copy of anything that he filled out. We were completely unaware of that.

The fact of the matter is, our only knowledge was that Dr. Highsmith performed surgery on injured people and filed their health insurance, because he had done it in the past. And in this case, we assumed that he did it in this case. What could be more clear? We said, "File his health insurance." Mr. DeMaskey -- Ms. DeMaskey said, "File my health insurance."

I think the big screw-up was Carolina Neurosurgery had just changed its business model within days of this accident. I think it may have been after the collision and before the surgery. I think that's the big screw-up. I just don't think the people upfront truly understood it, and because of that, Mr. DeMaskey had surgery with Dr. Highsmith. Unknown to Mr. DeMaskey, they weren't -- they didn't certify his procedures. I think -- that's just me. That's what I think.

Q As of the January 21st, 2019 e-mail, as of

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when Mr. DeMaskey was probably sent to Dr. Highsmith by his family doctor, Dr. Highsmith had accepted Bluecross/Blueshield. So I didn't have a contract with Carolina Neurosurgery. I didn't have an agreement with them.

What this shows is that we were just keeping everybody updated and advising Carolina Neurosurgery that it would be best to file Bluecross/Blueshield. And if they had done that, the $2,600 in care that had been provided up to that date would have been paid, and we wouldn't be here.

So as far as whether they're relying upon that or not, I can't put myself into their head. All I can tell you is what happened and what it means. I can tell you what I did. I can tell you what I was thinking, but I didn't have -- I didn't have a contract with Carolina Neurosurgery. Does that help?

Q So is this --

A Does that answer your question?

Q Is it D&M's position that Carolina Neurosurgery had no right to rely on statements in the January 21, 2019 e-mail transmitted at 9:24 a.m.?

MR. MACKELCAN: Object to the form.

THE WITNESS: I can't say to what was in their mind; I absolutely can't. We're just keeping

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them updated regarding everything that was occurring in this case.

BY MR. PENDARVIS:

Q Updated with truthful statements, is that what you're implying?

A At the time, that was what we understood to be true and correct. Yes.

Q So --

A There's -- there's no untruthful statements in there. I'm offended that you would suggest that anything in there is untruthful. You have to understand, Mr. Pendarvis: At the time that you said it, if later on it turns out to not be the case, that doesn't mean it was untruthful when it's said. Things change. And when things changed, we let Carolina Neurosurgery know, and they should have certified his surgeries.

The fact of the matter is, we thought and the DeMaskeys thought that Carolina Neurosurgery certified that both surgeries under his health insurance. Why would -- why would we not have that reasonable expectation based upon the facts as they exist?

Q Why wouldn't Carolina Neurosurgery have a reasonable expectation to believe that lawyers that are representing a patient that's being presented for

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elective surgery, that those lawyers are accurately stating the amount of coverage?

A Everything that -- I'm going to say it again: Everything that was stated was accurate at the time. When things changed, we updated Carolina Neurosurgery, and we provided them with information that was what we thought in their best interest to file it with Bluecross/Blueshield. They should have done that. And if they couldn't do that, they should have told us that, and they should have told DeMaskey that, and Mr. DeMaskey would have had surgery with someone else. We haven't -- we've done nothing wrong here.

Q It's clear this e-mail represents there's a million and one coverage and that the law firm's saying, "We're not concerned that there will be enough coverage overall to cover -- to pay this claim."

A Is that a question?

Q That's true, correct? That's what Carolina Neurosurgery heard from the lawyers, right?

A The e-mail says exactly what's in the e-mail. I've answered the same questions two times. If you want to ask me to answer it a third time, I'll be glad to do that. Well, this actually is the third time, but if you want to do it a fourth time, I'll do that. When you get to the fifth time, that might be

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A I know. It wasn't a good question, but go ahead. I did my best with it.

Q Topic No. 9 of the deposition notice deals with allegations in Paragraph 38 of the complaint and the corresponding denial of those allegations in the answer to the allegations in Paragraph 38. And I'll say to you, the answer states in response to the allegations in Paragraph 38, "Defendants admit only that Defendants do maintain and have maintained that Plaintiff should have submitted its invoices to the health insurance carrier for Defendant's client. Defendants deny the remaining allegations."

That's the part I want to find out today. What is the factual basis for denying the remaining allegations in Paragraph 38 of the complaint?

A I guess it's going to sound repetitious, but we at the time did not know that Dr. Highsmith's office did not accept Mr. DeMaskey's Bluecross/Blueshield insurance. We assumed that Dr. Highsmith was in-network because Dr. Highsmith had previously performed a major orthopaedic-type surgery on Mr. DeMaskey and used his Bluecross/Blueshield insurance.

Mr. DeMaskey did not know that Dr. Highsmith would not take his Bluecross/Blueshield insurance.

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The fact of the matter is, Mr. DeMaskey and Carol DeMaskey were aware that Dr. Highsmith assured them that the surgeries would be performed under his health insurance. So, yeah, that would be the basis of the denial. So I did not -- we did not know. We, I say I. We did know that Carolina Neurosurgery was out-of-network.

Q Okay. Anything else in response to that question?

A Yeah. Wouldn't it have been really easy when we advised Carolina Neurosurgery to file Bluecross/Blueshield health insurance, available Bluecross/Blueshield health insurance? Wouldn't it have been really easy for Kiara or Dr. Highsmith to simply say, "We're not in-network to provide it under your health insurance"? I keep asking myself. I keep coming back to that. And the answer is, yes, it would have been very easy. Should it have been done? The answer is also, yes. As far as the documents, all the documents speak for themselves.

Q And they disregard the law firm's statements about available underinsured coverage and accident insurance coverage as part of that decision to proceed with the Allstate policy you're describing?

A Well, now you're talking about something

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different.

Q I am.

A So I think we discussed, on multiple occasions, that what we represented with respect to the occupational policy was absolutely true at the time that it was represented. Same thing with the underinsured motorist coverage.

Q Okay. Now let's turn to Topic No. 10. This deals with the allegations in Paragraph 41 of the complaint and the corresponding Paragraph 41 in the answer denying the allegations in Paragraph 41 of the complaint. And I want to ask what is the factual basis for the denial of the allegations that Carolina Neurosurgery and the Defendants in this case, including D&M, entered into a contract described earlier as the LOP?

A I don't believe that the letter of protection is a contract; I just don't. It's just our standard letter of protection.

Q And how do you characterize the word "agreement" in that letter. We agree to do this, and you agree to do that; that's not a contract?

A It's not as if we sent Mr. DeMaskey to Dr. Highsmith's office and requested that he be seen and treated under a letter of protection. It's just

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our standard letter of protection. In this case, Mr. DeMaskey advised us that Carolina Neurosurgery wanted us to send it. We sent it on Mr. DeMaskey's behalf.

Q Is it D&M's position it had no obligation to perform the agreement that's stated in the letter?

A We would do exactly what's stated in the letter. The first letter of protection will protect your bill for services out of the proceeds or settlement or verdict in the event that there is sufficient, and the patient's ultimately responsible. As you know, attorneys can't guarantee payment to doctors. All we can -- all we can say is what we do out of proceeds of the settlement or verdict.

Q But that was an agreement, correct?

A It was on behalf -- between Mr. DeMaskey and Dr. Highsmith. Dr. Highsmith, they didn't bargain with us for it. They didn't say, "Hey, DeLuca & Maucher, send us a letter of protection, and we'll provide services." The fact of the matter is, they should have used the health insurance, the Bluecross/Blueshield. I've said it multiple times, and I'm sure I'll say it multiple times until we're done.

Q So are there any other factual things,

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events, conversations, documents that support the denial of the allegations that Carolina Neurosurgery and the lawyers, the Defendants entered into a contract described earlier as the LOP?

A I'll stand on all of my answers up to this point and no other documents.

Q Okay.

A Or conversations that I'm aware of at this time.

Q And Topic No. 11 -- thank you for that. Topic No. 11 for today relates to the allegations in Paragraph 43 of the complaint and the corresponding Paragraph 43 in the answer. Paragraph 43 in the complaint alleges the lawyers breached the LOP. And there's a denial of that. And how -- what's the basis for -- factual basis for the denial of those allegations?

A I stand by all my prior answers. This is the same question for the fifteenth time.

Q Well, not exactly. The allegations are that the lawyers breached the terms of a letter of protection. This is under the heading, breach of contract. So I have to disagree with your characterization. So I'm trying to find out, does the denial mean that there was a contract and it wasn't

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breached or there never was a contract or what?

A All the above. So at the time that we advised them -- well, prior to any surgeries being done, we advised them we essentially withdrew that letter of protection, then we gave a second letter of protection. We advised them to use his health insurance. So the essence of the letter of protection goes to the available health insurance, liability insurance and health insurance. So we still didn't have the liability issue clarified at that time.

But obviously, we were concerned enough that we advised Dr. Highsmith to not proceed under the letter of protection on behalf of Mr. DeMaskey but rather to file his Bluecross/Blueshield insurance. Dr. Highsmith had followed that, if Dr. Highsmith had listened to his patient and done that, he wouldn't have performed surgeries that were not covered.

Q Do you want to take a break?

A Yeah, let's go five minutes.

VIDEOGRAPHER: Off the record at 11:47.

VIDEOGRAPHER: On the record at 11:54.

BY MR. PENDARVIS:

Q Okay. Let's turn now to -- we finished 11. We're looking now at the Topic No. 12. This relates to the allegations in Paragraph 49, and I'm going to

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apologize on the record for the poor paragraph numbering in the original complaint. There's -- Microsoft and I were just not having a good day.

Anyway, the allegations about Paragraph 49 that we want to talk about is in Paragraph 49 on Page 10 of Exhibit 2. In its answer -- in their answer, the "Defendants admit only that they engaged in trade and commerce in practicing law in the course and scope of their representation of Defendants' client." The remaining allegations are denied. And I want to find out what's the factual basis for the denial of the allegations in Paragraph 49 of the complaint?

A Is that a question?

Q Yes.

A We have not engaged in unfair or deceptive practices, and we have not in our -- obviously, obviously. And then it goes on to say our deceptive acts or practices was willful. That's all denied. That's silly. That baffles me. That is preposterous. That is offensive. And all the facts, as I understand them, we -- we all have the same facts, all the same e-mails.

Q Are you able to identify any specific facts supporting the denial of the allegations in Paragraph 49?

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A That incorporate every statement and every document that we've talked about.

Q Turning to the next topic, which is the -- focuses on the allegations in Paragraph 50 that's -- and the corresponding denial of those allegations in Paragraph 50 of the answer, and Paragraph 50 in the complaint is that "Lawyer's conduct is capable of repetition," and it's been denied. I would like to find out the factual basis for the denial that the lawyers' conduct alleged in this complaint is not capable of repetition.

A All right. So I'm a little confused as where we are. What question on Exhibit No. 1 are we at?

Q The topic of examination is Topic No. 13.

A All right.

Q It's Page 7 carrying over to the top of Page 8. And it refers to Paragraph 50 in Exhibit 2 and Paragraph 50 in Exhibit 3.

A That's denied, correct. It should be denied.

Q It is, and I'm trying to understand the factual basis for denying the statement that the lawyers' conduct is capable of repetition. How is it not capable of repetition?

A This is a fact-dependent circumstance with Mr. DeMaskey going to Carolina Neurosurgery, a place

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where he's gone in the past to be treated by a doctor who's done surgery on him in the past. This is a very unique and singular event in the practice of law.

This case rises and falls on its facts. The fact of the matter is that DeLuca & Maucher, we were not false and deceptive. The fact of the matter is, DeLuca & Maucher, you would have us colluding with Mr. DeMaskey to obtain services and somehow deprive Dr. Highsmith and his practice of being paid. That's furthest from the truth.

If you take a step back and look at it all, we told Dr. Highsmith, "use his Bluecross/Blueshield health insurance so that you get paid." We didn't know that Dr. Highsmith did not take the DeMaskey's Bluecross/Blueshield health insurance. The fact of the matter is, Mr. DeMaskey and Ms. DeMaskey had no idea that Dr. Highsmith and Carolina Neurosurgery did not take his health insurance.

So this is a very specific event, and I think the mistake, if there are any, lies with Carolina Neurosurgery. So as I understand unfair trade practices and fraud and things like that, you have to show that something that's capable of repetition. I think that's like -- once again, I'm not nearly as smart as you or Beth, but I think it's capable of

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repetition's something that happens over and over, and that's just not the case here.

This is just very unique facts and circumstances. I've never run into a doctor -- a surgeon who doesn't take health insurance. I can't say offhand that I've ever run into anybody who's a surgeon. So, no, I don't think it's capable of repetition at all. I think that would be the basis for denying that. And of course, my attorney, who is very smart, might have another explanation for that.

Q We're here today to get D&M's position on it, and it was a properly-noticed deposition. And you're here to give testimony on behalf of D&M. Didn't D&M testify earlier today that this letter of protection attached as Page 2 of Exhibit 6 of the complaint is a standard letter of protection?

A Correct.

Q Didn't that testify earlier?

A Correct.

Q So if it's a standard letter, has it been out -- been issued more than once?

A Right, but I think --

Q No, answer the question. Yes, has it been issued more than once?

A Yes.

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Q How many times, approximately?

A Often.

Q Hundreds?

A Probably more. Thousands.

Q Okay. So if D&M has issued hundreds of these letters of protection, how can it factually claim that this isn't -- this whole series of events is not capable of repetition?

A Easy. Because it says, the letter of protection that we sent, not paid by health insurance. They didn't file health insurance. That was a condition preceding. This is a unique circumstance. And that second letter of protection was sent before any of the surgeries. So, yeah, I stand by it. You may not like the answer, but you have to accept it.

I don't think it's capable of repetition. I think this is a very unique circumstance in which Dr. Highsmith and his office ignored very clear instruction to file the patient's Bluecross/Blueshield insurance from my office and ignored very clear instruction from the patient to file Bluecross/Blueshield insurance. Yeah, I think it's a unique circumstance. So I'm comfortable with the denial that our attorney filed on our behalf.

Q Turning now to Topic 14, identify the facts

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CareWorks

Explanation of Review

EXHIBIT K

2000 Mallory Lane
Ste 130-280
Franklin, TN 37067
615-399-8658
877-494-7937

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Provider: HIGHSMITH ,JASON
7301 RIVERS AVE STE 242
Charleston, SC 29406

Treating Provider: HIGHSMITH ,JASON
Account #: [redacted]

Claim Jurisdiction: SC
Carrier Received: 07/07/23
Date Received: 07/07/23
Date Printed: 07/17/23
Processor: GW
Review #: 1[redacted]
Document Name: [redacted]

Bill Type: Office Visit

Client: INTACT INSURANCE
[redacted]

Patient: DEMASKEY, [redacted]

Dates of Service: 01/02/19 - 01/02/19

Diagnosis Code(s)
M542 [redacted]
M5412 [redacted]
M545 [redacted]
M5430 [redacted]

Provider TIN: [redacted]
Rendering Zip: 29406
Adjuster: KMGANT
Employer:

Claim #: [redacted]
DOI: 12/14/18
Coverage: Workers Compensation

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Quality Code
1	01/02/19	99204	[redacted] 45 MIN	1	$900.00	$681.00	$0.00	$0.00	$219.00	FS001
			Totals:	**1**	**$900.00**	**$681.00**	**$0.00**	**$0.00**	**$219.00**	

0000000450

Qualify Code Descriptions:

FS001 - FEE SCHEDULE REDUCTION - STANDARD

Notes:

The patient is covered under an Occupational Accident Policy. Unless otherwise noted, charges were reduced by the lesser of the usual and customary charge for the service, treatment or supply as reflected in the local Workers' Compensation schedule or negotiated rate. All treatment and services must be due to the covered injury.

For questions regarding, this review please contact CareWorks at 615-399-8658 877-494-7937

CareWorks

Explanation of Review

2000 Mallory Lane
Ste 130-280
Franklin, TN 37067
615-399-8658
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Provider: HIGHSMITH ,JASON
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Date Printed: 07/17/23
Processor: GW
Review #: [redacted]
Document Name: [redacted]

Bill Type: Office Visit

Client: INTACT INSURANCE
[redacted]

Patient: DEMASKEY, [redacted]
[redacted]

Dates of Service: 01/21/19 - 01/21/19

Diagnosis Code(s)
M50220 [redacted]
M5126 [redacted]

Provider TIN: 811234492
Rendering Zip: 29406
Adjuster: KMGANT
Employer:

Claim #: [redacted]
DOI: 12/14/18
Coverage: Workers Compensation

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Quality Code
1	01/21/19	99214	[redacted]	1	$480.00	$336.50	$0.00	$0.00	$143.50	FS001
2	01/21/19	76140	[redacted]	1	$180.00	$140.00	$0.00	$0.00	$40.00	UC001
3	01/21/19	72141 26	[redacted]	1	$300.00	$198.50	$0.00	$0.00	$101.50	FS001
4	01/21/19	72148 26	[redacted]	1	$300.00	$198.50	$0.00	$0.00	$101.50	FS001
			Totals:	**4**	**$1,260.00**	**$873.50**	**$0.00**	**$0.00**	**$386.50**	

0000000450

Qualify Code Descriptions:

FS001 - FEE SCHEDULE REDUCTION - STANDARD
UC001 - USUAL AND CUSTOMARY REDUCTION - STANDARD FAIR HEALTH

Notes:

The patient is covered under an Occupational Accident Policy. Unless otherwise noted, charges were reduced by the lesser of the usual and customary charge for the service, treatment or supply as reflected in the local Workers' Compensation schedule or negotiated rate. All treatment and services must be due to the covered injury.

For questions regarding, this review please contact CareWorks at 615-399-8658 877-494-7937

CareWorks

Explanation of Review

2000 Mallory Lane
Ste 130-280
Franklin, TN 37067
615-399-8658
877-494-7937

ELECTRONICALLY FILED - 2024 Aug 14 12:40 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Provider: HIGHSMITH ,JASON
7301 RIVERS AVE STE 242
Charleston, SC 29406

Treating Provider: HIGHSMITH ,JASON
Account #: [redacted]

Claim Jurisdiction: SC
Carrier Received: 07/07/23
Date Received: 07/07/23
Date Printed: 07/17/23
Processor: GW
Review #: [redacted]
Document Name: [redacted]

Bill Type: Office Visit

Client: INTACT INSURANCE
[redacted]

Patient: DEMASKEY, [redacted]

Dates of Service: 03/07/19 - 03/07/19

Diagnosis Code(s)
M545 [redacted]

Provider TIN: [redacted]
Rendering Zip: 29406
Adjuster: KMGANT
Employer:

Claim #: [redacted]
DOI: 12/14/18
Coverage: Workers Compensation

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Quality Code
1	03/07/19	99214	[redacted]	1	$480.00	$336.50	$0.00	$0.00	$143.50	FS001
			Totals:	**1**	**$480.00**	**$336.50**	**$0.00**	**$0.00**	**$143.50**	

0000000450

Qualify Code Descriptions:

FS001 - FEE SCHEDULE REDUCTION - STANDARD

Notes:

The patient is covered under an Occupational Accident Policy. Unless otherwise noted, charges were reduced by the lesser of the usual and customary charge for the service, treatment or supply as reflected in the local Workers' Compensation schedule or negotiated rate. All treatment and services must be due to the covered injury.

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ELECTRONICALLY FILED - 2024 Aug 14 12:40 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Provider: HIGHSMITH ,JASON
7301 RIVERS AVE STE 242
Charleston, SC 29406

Treating Provider: HIGHSMITH ,JASON
Account #: [redacted]

Claim Jurisdiction: SC
Carrier Received: 07/07/23
Date Received: 07/07/23
Date Printed: 07/17/23
Processor: GW
Review #: 1[redacted]
Document Name: [redacted]

Bill Type: Surgery

Client: INTACT INSURANCE
[redacted]

Patient: DEMASKEY, [redacted]

Dates of Service: 03/15/19 - 03/15/19

Diagnosis Code(s)
M50223 [redacted]
M5412 [redacted]

Provider TIN: [redacted]
Rendering Zip: 29456
Adjuster: KMGANT
Employer:

Claim #: [redacted]
DOI: 12/14/18
Coverage: Workers Compensation

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Quality Code
1	03/15/19	22551	[redacted]	1	$43,692.28	$41,458.78	$0.00	$0.00	$2233.50	FS001
2	03/15/19	22845	[redacted]	1	$8,092.44	$7,132.94	$0.00	$0.00	$959.50	FS001 R51B
3	03/15/19	22853	[redacted]	1	$6,912.69	$6,579.69	$0.00	$0.00	$333.00	FS001 R51B
			Totals:	**3**	**$58,697.41**	**$55,171.41**	**$0.00**	**$0.00**	**$3,526.00**	

0000000450

Qualify Code Descriptions:

FS001 - FEE SCHEDULE REDUCTION - STANDARD
R51B - THE PROCEDURE DOES NOT FALL WITHIN THE MEDICARE MULTIPLE PROCEDURE GUIDELINES, THEREFORE RECOMMENDED PAYMENT IS BASED ON 100% OF THE ALLOWED AMOUNT FOR THE PROCEDURE BILLED OR THE BILLED AMOUNT, WHICHEVER IS LESS.

Notes:

The patient is covered under an Occupational Accident Policy. Unless otherwise noted, charges were reduced by the lesser of the usual and customary charge for the service, treatment or supply as reflected in the local Workers' Compensation schedule or negotiated rate. All treatment and services must be due to the covered injury.

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ELECTRONICALLY FILED - 2024 Aug 14 12:40 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Provider: HIGHSMITH ,JASON
7301 RIVERS AVE STE 242
Charleston, SC 29406

Treating Provider: HIGHSMITH ,JASON
Account #: [redacted]

Claim Jurisdiction: SC
Carrier Received: 07/07/23
Date Received: 07/07/23
Date Printed: 07/17/23
Processor: GW
Review #: [redacted]
Document Name: [redacted]

Bill Type: Surgery

Client: INTACT INSURANCE
[redacted]

Patient: DEMASKEY [redacted]
[redacted]

Dates of Service: 05/02/19 - 05/02/19

Diagnosis Code(s)
M5126 [redacted]

Provider TIN: [redacted]
Rendering Zip: 29456
Adjuster: KMGANT
Employer:

Claim #: [redacted]
DOI: 12/14/18
Coverage: Workers Compensation

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Quality Code
1	05/02/19	63047	[redacted]	1	$43,857.77	$42,416.27	$0.00	$0.00	$1441.50	FS001
2	05/02/19	63048	[redacted]	1	$18,594.10	$18,316.10	$0.00	$0.00	$278.00	FS001 R51B
			Totals:	**2**	**$62,451.87**	**$60,732.37**	**$0.00**	**$0.00**	**$1,719.50**	

0000000450

Qualify Code Descriptions:

FS001 - FEE SCHEDULE REDUCTION - STANDARD
R51B - THE PROCEDURE DOES NOT FALL WITHIN THE MEDICARE MULTIPLE PROCEDURE GUIDELINES, THEREFORE RECOMMENDED PAYMENT IS BASED ON 100% OF THE ALLOWED AMOUNT FOR THE PROCEDURE BILLED OR THE BILLED AMOUNT, WHICHEVER IS LESS.

Notes:

The patient is covered under an Occupational Accident Policy. Unless otherwise noted, charges were reduced by the lesser of the usual and customary charge for the service, treatment or supply as reflected in the local Workers' Compensation schedule or negotiated rate. All treatment and services must be due to the covered injury.

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ELECTRONICALLY FILED - 2024 Aug 14 12:40 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

Provider: HIGHSMITH ,JASON
7301 RIVERS AVE STE 242
Charleston, SC 29406

Treating Provider: HIGHSMITH ,JASON
Account #: [redacted]

Claim Jurisdiction: SC
Carrier Received: 07/07/23
Date Received: 07/07/23
Date Printed: 07/17/23
Processor: GW
Review #: [redacted]
Document Name: [redacted]

Bill Type: Radiology

Client: INTACT INSURANCE
[redacted]

Patient: DEMASKEY, [redacted]

Dates of Service: 07/18/19 - 07/18/19

Diagnosis Code(s)
M545 [redacted]

Provider TIN: [redacted]
Rendering Zip: 29406
Adjuster: KMGANT
Employer:

Claim #: [redacted]
DOI: 12/14/18
Coverage: Workers Compensation

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Quality Code
1	07/18/19	99024	[redacted]	1	$0.00	$0.00	$0.00	$0.00	$0.00	UC001
2	07/18/19	76140 26	[redacted]	1	$180.00	$140.00	$0.00	$0.00	$40.00	UC001
			Totals:	**2**	**$180.00**	**$140.00**	**$0.00**	**$0.00**	**$40.00**	

0000000450

Qualify Code Descriptions:

UC001 - USUAL AND CUSTOMARY REDUCTION - STANDARD FAIR HEALTH

Notes:

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615-399-8658
877-494-7937

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Provider: HIGHSMITH ,JASON
7301 RIVERS AVE STE 242
Charleston, SC 29406

Treating Provider: HIGHSMITH ,JASON
Account #: [redacted]

Claim Jurisdiction: SC
Carrier Received: 07/07/23
Date Received: 07/07/23
Date Printed: 07/17/23
Processor: GW
Review #: [redacted]
Document Name: [redacted]

Bill Type: Office Visit

Client: INTACT INSURANCE
[redacted]

Patient: DEMASKEY, [redacted]

Dates of Service: 08/06/19 - 08/06/19

Diagnosis Code(s)
M545 [redacted]

Provider TIN: 811234492
Rendering Zip: 29406
Adjuster: KMGANT
Employer:

Claim #: [redacted]
DOI: 12/14/18
Coverage: Workers Compensation

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Quality Code
1	08/06/19	99214	[redacted]	1	$480.00	$335.50	$0.00	$0.00	$144.50	FS001
			Totals:	**1**	**$480.00**	**$335.50**	**$0.00**	**$0.00**	**$144.50**	

0000000450

Qualify Code Descriptions:

FS001 - FEE SCHEDULE REDUCTION - STANDARD

Notes:

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Provider: HIGHSMITH ,JASON
7301 RIVERS AVE STE 242
Charleston, SC 29406

Treating Provider: HIGHSMITH ,JASON
Account #: [redacted]

Claim Jurisdiction: SC
Carrier Received: 07/07/23
Date Received: 07/07/23
Date Printed: 07/17/23
Processor: GW
Review #: [redacted]
Document Name: [redacted]

Bill Type: Office Visit

Client: INTACT INSURANCE
[redacted]

Patient: DEMASKEY, [redacted]
[redacted]

Dates of Service: 12/20/19 - 12/20/19

Diagnosis Code(s)
M545 [redacted]

Provider TIN: [redacted]
Rendering Zip: 29406
Adjuster: KMGANT
Employer:

Claim #: [redacted]
DOI: 12/14/18
Coverage: Workers Compensation

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Quality Code
1	12/20/19	99214	[redacted]	1	$480.00	$335.50	$0.00	$0.00	$144.50	FS001
			Totals:	**1**	**$480.00**	**$335.50**	**$0.00**	**$0.00**	**$144.50**	

0000000450

Qualify Code Descriptions:

FS001 - FEE SCHEDULE REDUCTION - STANDARD

Notes:

The patient is covered under an Occupational Accident Policy. Unless otherwise noted, charges were reduced by the lesser of the usual and customary charge for the service, treatment or supply as reflected in the local Workers' Compensation schedule or negotiated rate. All treatment and services must be due to the covered injury.

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EXHIBIT L

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intact INSURANCE

Claims Processing Center
188 Inverness Drive W., Suite 600
Englewood CO 80112

Mail to:

000001 - 0261

JASON HIGHSMITH MD
7301 RIVERS AVE STE 242
NORTH CHARLESTON SC 29406-4616

intact INSURANCE

Claims Processing Center
188 Inverness Drive W., Suite 600
Englewood CO 80112

EXPLANATION OF PAYMENT 2120042605

PAY TO: CAROLINA NEUROSURGERY & ORTHOPEDICS INC

COMPANY:	ATLANTIC SPECIALTY INSURANCE COMPANY
DATE ISSUED:	07/20/2023
CHECK AMT:	$6323.50
INSURED:	SUPERIOR BULK LOGISTICS, INC. DBA SUPERIOR CARRIE
POLICY NO:	2160001880012
DATE/LOSS:	12/14/2018
CLAIM NO.:	0AB245416-01-01
CLAIM TYPE:	MEDICAL (NC)
CLAIMANT:	[redacted] DEMASKEY
ADJUSTER:	KRISTI GANT

AGENT: COTTINGHAM & BUTLER INSURANCE SERVICES
800 MAIN STREET
DUBUQUE, IA 52001

IN PAYMENT OF: OFFICE VISIT AND RADIOLOGY AND SURGERY

SERVICE DATES: 01/02/2019 THRU 12/20/2019

INVOICE NUMBER: BULK PAYMENT X 8 - 177271

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND. SECURITY FEATURES INCLUDE THERMOCHROMIC INK, MICROPRINTING, A VOID PANTOGRAPH, AND AN ARTIFICIAL WATERMARK AND SECURITY SCREEN ON THE BACK.

intact INSURANCE

Claims Processing Center
188 Inverness Drive W., Suite 600
Englewood CO 80112

93-445/929

Check Number	Date
[redacted]	07/20/2023

ALL PAYEES MUST ENDORSE

Amount
$******6,323.50

PAY TO THE ORDER OF: CAROLINA NEUROSURGERY & ORTHOPEDICS INC

IN PAYMENT OF: OFFICE VISIT AND RADIOLOGY AND SURGERY

PAY EXACTLY SIX THOUSAND THREE HUNDRED TWENTY THREE DOLLARS AND 50 CENTS

NOT VALID AFTER 90 DAYS FROM ISSUE

usbank.

AUTHORIZED SIGNATURE

INSURED: SUPERIOR BULK LOGISTICS, INC. DBA SUPERIOR CARRIE
POLICY NO: 2160001880012
CLAIM NO: 0AB245416-01-01
CLAIMANT: [redacted] DEMASKEY

ADJUSTER: KRISTI GANT
LOSS DATE: 12/14/2018
CLM TYPE: MEDICAL (NC)

GN8P

T1D101 - 41988276-000289-01/01-0-0-0

[redacted]

ELECTRONICALLY FILED - 2024 Aug 14 2:13 PM - CHARLESTON - COMMON PLEAS - CASE#2021CP1003379

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	IN THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopaedics, Inc.,	)	
	)	**DEFENDANTS' MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION TO AMEND**
Plaintiff,	)	
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	
	)	

Michael A. Maucher, Esq. and Deluca & Maucher, LLP, by and through their undersigned counsel, submit this Memorandum in Opposition to Plaintiff's Motion to Amend, requesting this Court deny Plaintiff leave to amend.

INTRODUCTION

This case arises from Plaintiff's failure to exercise due diligence and follow its financial policy before proceeding with approximately $125,000.00 in surgical treatment for one of Defendants' clients (Client), who was injured in a motor vehicle collision on December 14, 2018. Defendants were unaware that Plaintiff and its surgeon, Dr. Highsmith, were "out of network" healthcare providers under Client's private health insurance.

Further, despite repeated instructions from both Defendants and Client regarding billing insurance for Plaintiff's services, Plaintiff never attempted to: (1) confirm with Defendants its network status with Client's health insurance; or (2) submit the proposed procedures to the Client's health insurance for pre-approval before proceeding with the surgeries. Until recently, however, Plaintiff had never attempted to submit claims for payment to the Client's health insurance following each of the surgeries. Moreover—despite Defendants' offer to pay Plaintiff

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out of the $30,000 settlement proceeds recovered for their client—Plaintiff not only rejected such offer, but it brought a debt collection action against Defendants' client in the Berkeley County, South Carolina Court of Common Pleas.[1] Plaintiff and Client resolved their case before trial, with Plaintiff accepting partial payment from Client's insurer for Client's medical bills Plaintiff asserts Defendants owe.

SUMMARY OF FACTS

Client was injured in a car accident on December 14, 2018. **Cmplt. ¶ 7**. Shortly thereafter, he retained Defendants to pursue claims against the at-fault driver. Before the accident, Client was a patient of Dr. Highsmith and Carolina Neurosurgery. **Cmplt. ¶ 7**. Client chose to return to Dr. Highsmith to treat the injuries he sustained in the car accident.

Defendants sent Plaintiff a letter of protection on December 20, 2018, that stated:

> Please accept this correspondence as our Law Firm's agreement to protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance.

Ex. A (First Letter of Protection).

On January 3, 2019, Client executed Plaintiff's Financial Policy. **Ex. B.** Under the section entitled "If you have insurance," the Financial Policy provides that Plaintiff "will file with [the patient's] primary insurance." **Ex. B.** The Financial Policy also provides that the patient may be responsible for all of part of the balance not paid by the insurance company. **Ex. B**. At the time, Client had primary health insurance through Blue Cross/Blue Shield.

On January 21, 2019, Tina Bennett, a paralegal with Defendant Law Firm, responded to an inquiry from Kiara Goodwine, Plaintiff's employee, regarding the "limits" for Client,

[1] *Carolina Neurosurgery and Orthodontics, Inc. v. Scott Demaskey*, 2021CP0801088.

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explaining the at-fault carrier was from North Carolina and would not disclose policy limits without a medical authorization, and they were unable to discover how much liability coverage the at-fault driver had. **Ex. C**. However, Bennett informed Goodwine that Client had $100,000 in UIM coverage on a Safeco Policy and carried $1,000,000 in "Occupational Accident Coverage" on a One Beacon policy. **Ex. C**.

Hours later the same day, Bennett emailed Goodwine and explained Client advised that he required surgery. **Ex. C**. Based on the seriousness of the injury, and pre-existing injuries, Bennett requested all of Client's treatment be filed with his private health insurance company. Further, that it "would be best for everyone involved if we NOT do the treatment under an Assignment/Letter of Protection." **Ex. C.** Goodwine responded, "Okay thanks for the update." **Ex. C**.

On March 7, 2019, Defendant Law Firm sent a revised Letter of Protection to Plaintiff, stating:

> Please accept this correspondence as our Law Firm's agreement to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance.

Ex. D (Second Letter of Protection). That same day, Client completed a Health Insurance Verification form for his upcoming surgery, providing Plaintiff with his BlueCross/BlueShield insurance information and the document was signed by Goodwine. **Ex. E.**

Highsmith performed Client's first surgery on March 15, 2019 (First Surgery) and charged Client $58,697.41. For the First Surgery, Plaintiff did not submit any bills to BlueCross/BlueShield, despite the language in the Letter of Protection and Client providing his insurance information.

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As Client's personal injury case developed, it was determined that: (1) the at-fault driver did not have sufficient insurance coverage to fully cover Client's medical treatment; (2) one of Client's other additional policies was inapplicable; and (3) the other additional policy was subject to subrogation and only applicable after Client's primary private health insurance had been exhausted.

On April 29, 2019, Defendants notified Plaintiff via email of the foregoing issues, stating:

> Because the at-fault party only had $30,000.00 and [Client's] Underinsured Motorist Coverage does not apply, **ALL of the treatment [Client] has received (and will continue to receive) must be filed under his private health insurance.** We cannot honor anymore treatment under a Letter of Protection. Please note [Client] file accordingly.

Compl. ¶ 29 (emphasis in original).[2]

On May 2, 2019, Highsmith performed additional surgery on Client, charging him an additional $62,451.87 (Second Surgery). **Ex. F**. In total, Plaintiff charged Client $125,409.28. **Ex. F.** Despite receiving explicit instructions regarding claim submission and payment on several occasions prior to both surgeries, Plaintiff did not file claims with Client's private health insurance. On January 3, 2020, Bennett wrote Goodwine and reminded her of the Letters of Protection, and that it appeared Client's health insurance did not pay any of Plaintiff's bills. **Ex. G**. Bennett explained there was only $30,000 in coverage to pay the claim and they needed to discuss how to allocate that amount amongst everyone. **Ex. G.**

Because Client has been unable to pay for Plaintiff's services, Plaintiff initiated a debt collection action against him on May 21, 2021. Further, Plaintiff has demanded payment from

[2] It is anticipated Plaintiff may contest the authenticity of the email. However, Plaintiff's complaint alleges the email was sent to it and Defendants admitted the allegation in their answer. ***Compare* Compl. ¶29 *with* Ans. ¶29.** Because Defendants admitted the fact as Plaintiff pled it, it is conclusively proven for the purposes of trial.

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Defendants for Client's medical bills. Defendants have attempted to tender payment to Plaintiff out of the settlement proceeds, and Plaintiff refused it. Moreover, the settlement proceeds are currently being held in Defendant Law Firm's trust account, and Defendants will not receive any of the funds upon resolution of this matter.

Current Lawsuit

Plaintiff filed this action on July 22, 2021, asserting claims for (1) breach of contract, (2) breach of contract accompanied by a fraudulent act, (3) violation of the S.C. Unfair Trade Practice Act, (4) fraud, (5) constructive fraud, (6) unjust enrichment, and (7) negligence. ***See* Compl**. In its summary, Plaintiff explained the case arose from Defendants' "false or inaccurate representations about the availability of liability and homeowners' insurance coverage" and "promises in a letter of protection" that led Plaintiff "to perform over $125,000" in medical care. **Compl. ¶ 1**.

Defendants moved to dismiss Plaintiff's claims, which was granted in part, and the only remaining claims are for (1) Breach of Contract and (2) Violation of the SC Unfair Trade Practice Act. **Ex. H (Order Granting Motion)**. That order made numerous findings of fact and conclusions of law that are now the law of the case. *See* **Ex. H**. There is, however, one caveat—that the "order will not be admissible . . . to prove or disprove any matter of fact or establish or challenge any conclusion of law with respect to *Plaintiff's remaining claims for Breach of Contract and violation of the South Carolina Unfair Trade Practice Act.*" **Ex. H** (emphasis added).

The Court entered a consent scheduling order on September 26, 2022, with a mediation deadline, discovery deadline of June 5, 2023, and a trial not before date of September 4, 2023. **Ex. I (Scheduling Order)**. The parties engaged in substantial written discovery and document

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production, and deposed Dr. Highsmith and Defendant DeLuca & Maucher. Defendants responded to Plaintiff's interrogatories and requests for production. **Ex. J (Defs' Discovery Responses).** Plaintiff responded to Defendants' interrogatories and requests for production, and supplemented its responses. **Ex. K (Pltf's responses)**. Defendants deposed Dr. Highsmith based on the allegations in the operative complaint, obtaining testimony relevant to the breach of contract claim as pled. Plaintiff then took the deposition of DeLuca & Maucher. Plaintiff's deposition notice was based almost entirely on the complaint and answer, demanding a representative from DeLuca & Maucher be prepared to defend nearly every position the Defendants took in denying allegations and asserting affirmative defenses. **Ex. L (Notice of D&M Deposition)**.

Defendants moved for summary judgment on August 22, 2023, asking the Court to grant judgment based on the pleadings and discovery up to that date. Two weeks later, Plaintiff moved to amend the complaint to change the theories of recovery and add two additional claims. **Pltfs. Mtn. to Amnd.**

Proposed Amended Complaint

Plaintiff's Proposed Amended Complaint asserts four causes of action, (1) breach of contract, (2) violation of S.C. Unfair Trade Practice Act, (3) Negligent Misrepresentation, and (4) promissory estoppel.

Plaintiff now describes the case as arising from "false and inaccurate representations about the availability of $1,000,000 in insurance coverage [Defendants] were pursuing to cover medical and surgical expenses" for a client "that induced Plaintiff to perform over $125,000" in medical services. **Prop. Amnd. Compl. ¶ 1**.

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Plaintiff's breach of contract action is currently based on the Letters of Protection. However, Plaintiff has abandoned that theory and switched it out to now say that a contract was formed based on the email from Tina Bennett identifying Client's policy limits. Notably, the factual allegations in the proposed amended complaint shy away from repeatedly referencing the Letters of Protection, and focus on the references in an email from Tina Bennett identifying policies and limits. Plaintiff also adds two claims, negligent misrepresentation and promissory estoppel, based on the alleged representations of the insurance policy limits.

Defendants request this Court deny Plaintiff leave to amend the Complaint for the reasons outlined below.

STANDARD OF REVIEW

A motion to amend is within the sound discretion of the circuit court and, therefore, is reviewed for abuse of discretion. *Foggie v. CSX Transp., Inc.*, 315 S.C. 17, 431 S.E.2d 587 (1993). "If more than thirty days have elapsed from the time a responsive pleading is served, a party may amend his pleading only by leave of court or by written consent of the adverse party." *Stanley v. Kirkpatrick*, 357 S.C. 169, 175, 592 S.E.2d 296, 298 (2004).

ARGUMENT

I. This Court should deny Plaintiff leave to amend the complaint due to Plaintiff's undue delay in seeking leave to amend, the prejudice to Defendants, and Plaintiff's suspect motive.

Leave to amend "shall be freely given when justice so requires and does not prejudice any other party." Rule 15(a), SCRCP. The power to amend, however, "is not unlimited and it is a mistake to suppose that any and everything that may be proposed by way of amendment is allowable provided it is proposed before trial." *Alamance Indus. v. Chesterfield Hosiery Mill*, 239 S.C. 287, 290, 122 S.E.2d 648, 649 (1961).

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> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason—such as undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, futility of amendment, etc.—the leave sought should, as the rules require, be "freely given."

Patton v. Miller, 420 S.C. 471, 490, 804 S.E.2d 252, 262 (2017) (quoting *Foman v. Davis*, 371 U.S. 178, 182 (1962)). "Courts have wide latitude in amending pleadings and '[w]hile this power should not be used indiscriminately or to prejudice or surprise another party, the decision to allow an amendment is within the sound discretion of the trial court and will rarely be disturbed on appeal.'" *Duncan v. CRS Sirrine Engineers, Inc.*, 337 S.C. 537, 542, 524 S.E.2d 115, 118 (Ct. App. 1999) (quoting *Berry v. McLeod,* 328 S.C. 435, 450, 492 S.E.2d 794, 802 (Ct. App.1997)).

Our courts rely upon treatises interpreting federal Rule 15 to interpret and apply Rule 15 of the South Carolina Rules of Civil Procedure. *See Forrester v. Smith & Steele Builders, Inc.*, 295 S.C. 504, 506, 369 S.E.2d 156, 158 (Ct. App. 1988) (utilizing J. Moore's *Federal Practice* to interpret Rule 15, SCRCP); *Potomac Leasing Co. v. Bone*, 294 S.C. 494, 497, 366 S.E.2d 26, 28 (Ct. App. 1988) (same). Our courts have also relied upon Wright & Miller's Federal Practice and Procedure when interpreting Rule 15 of South Carolina Rules of Civil Procedure. *See Skydive Myrtle Beach, Inc., v. Horry County*, 426 S.C. 175, 183, 826 S.E.2d 585, 589 (2019) (relying on and quoting Wright & Miller's Federal Practice and Procedure section 1487 (3d ed. 2010) to interpret futility under Rule 15, SCRCP).

South Carolina case law, in conjunction with recognized treatises interpreting Rule 15, FRCP, justify denying Plaintiff leave to amend because Plaintiff unduly delayed in seeking leave

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to amend, Defendants would be prejudiced by the amendment, and Plaintiff's delay is indicative of bad faith or dilatory motive.

A. Plaintiff should be denied leave to amend because Plaintiff's delay in seeking leave to amend is undue and inexcusable.

Amendments may be properly denied when there are circumstances such as inexcusable delay, or the taking of an adverse party by surprise. *Braudie v. Richland County*, 217 S.C. 57, 59, 59, S.E.2d 548, 549 (1950); *Dunbar v. Carlson*, 341 S.C. 261, 533 S.E.2d 913 (Ct. App. 2000); *Crowley v. Spivey*, 285 S.C. 397, 414, 329 S.E.2d 774, 784 (Ct. App. 1985) (stating the decision to amend the pleadings is within the circuit court's discretion, and circumstances such as inexcusable delay and surprise to the adverse party justify a refusal to amend).

The purpose of Rule 15 is to facilitate the determination of an action on its merits and, therefore, a motion to amend needs to be made as soon as the necessity for altering the pleading becomes apparent. 6 Wright & Miller, *Federal Practice and Procedure* § 1488 (3d ed. 2010). "The function of Rule 15(a) . . . is to enable a party to assert matters that were overlooked or were unknown at the time the party interposed the original complaint or answer." *Id.* at § 1473. "A party who delays in seeking an amendment is acting contrary to the spirit of the rule and runs the risk of the court denying permission because of the passage of time." *Id.* at § 1488. "As a general rule, the risk of substantial prejudice increases with the passage of time." *Id.*

Our courts have found inexcusable delay justifies denying leave to amend in circumstances when the party requesting the amendment knew or had reason to know of the factual basis for the amendment at the time the original suit was filed. *Crowley*, 285 S.C. at 414, 329 S.E.2d at 784; *Alamance Indus.*, 239 S.C. at 290, 122 S.E.2d at 649. For example, in *Crowley*, the court of appeals affirmed the circuit court's decision denying leave to amend an answer to add the defense of contributory negligence because of the defendant's inexcusable

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delay. 285 S.C. at 414, 329 S.E.2d at 784. The lawsuit was filed in June 1980, sixteen months had passed, and in November 1981 before trial, the defendant sought to add contributory negligence as a defense. *Id.* at 413-14, 329 S.E.2d at 784. The defendant claimed it had just learned of the factual basis for contributory negligence via deposition testimony four days earlier. *Id.* at 413, 329 S.E.2d at 784. The court denied leave to amend, finding the defendant had known the factual basis for contributory negligence based upon the original complaint and previous depositions. *Id.* The passage of time was considered inexcusable delay, and the court of appeals affirmed the circuit court's denial of leave to amend. *Id.*

The same result was reached in *Alamance Industries* where the delay was eight months. *See Alamance Indus.*, 239 S.C. at 290, 122 S.E.2d at 649 (finding denial of leave to amend appropriate then defendant was aware of the factual matter that was the subject of the proposed amendment from the time the suit was commenced eight months earlier). Courts also note whether there is a reason for the delay in moving to amend, and will deny leave to amend when the delay is inexplicable. *See Health Promotion Specialists, LLC v. S.C. Bd. of Dentistry*, 403 S.C. 623, 632, 743 S.E.2d 808, 813 (2013) (affirming circuit court denial of leave to amend because the parties had engaged in extensive discovery, but there were no significant factual developments that warranted the untimely amendment).

Here, Plaintiff asserts generally that "the status of this case establishes the Defendants will not be able to show prejudice from an amendment adding additional legal theories." However, Plaintiff knew or should have known of the basis for amending the pleadings at the time it filed suit against Defendants, and many times thereafter.

When Plaintiff filed the suit, on July 22, 2021, Plaintiff included allegations about the January 21, 2019 email referencing insurance policies and limits, and included it as an exhibit in

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the Complaint. ***See* Compl. ¶ 19, Ex. 4**. However, Plaintiff's breach of contract action was based on the Letter of Protection, not any assurances about policy limits or coverage. Instead, Plaintiff asserted other causes of action based, in part, about representations of coverage, including breach of contract accompanied by a fraudulent act (**Cmpl. ¶ 40**); fraud (**Compl. ¶ 47**); constructive fraud (**Compl. ¶ 65**); and negligence (**Compl. ¶ 78**). Given the repeated references incorporating the alleged statements in the January 21, 2019 email throughout the original complaint, there is no question that Plaintiff knew of the factual basis upon which it rests its request to amend the pleadings—to change the theory under the breach of contract action based on statements about insurance coverage. Yet Plaintiff waited over two years to ask for permission to amend the complaint. The *Crowley* court found that 16 months was inexcusable delay, and the *Alamance* court found an 8-month delay was inexcusable. Consistent with *Crowley* and *Alamance*, the two-year delay in seeking approval to amend is inexcusable. In fact, Plaintiff does not even attempt to explain, i.e., excuse, the delay. Thus, the delay in seeking leave to amend was inexcusable and justifies denying the motion to amend.

Plaintiffs' failure to seek leave to amend earlier is even more inexcusable, considering the Court partially granted Defendants' Motion to Dismiss, dismissing claims of (1) breach of contract accompanied by a fraudulent act, (2) fraud, (3) constructive fraud, (4) unjust enrichment and negligence. The claims that were dismissed were based, in part, on allegations related to statements about insurance coverage. **Ex. H**. Plaintiff did not seek to amend its Complaint in response to the motion, at the hearing, or immediately after the order was entered. Considering the order made conclusions of law on some claims that involved allegations on insurance coverage, Plaintiff should have moved to amend earlier if it wanted to change the entire theory of its case based on evidence it already had. The delay in light of the Order, is inexcusable.

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Plaintiff's failure to seek leave at various significant developments in the case is also inexcusable. Plaintiff chose to continue with written discovery, document production, and depositions based on the remaining portions of the operative complaint—which were the breach of contract action based on the Letter of Protection and the SCUTPA claim. Defendants deposed Dr. Highsmith on May 19, 2023, and questioned him based on his allegations that the Letter of Protection was a contract because that was the primary remaining claim. Dr. Highsmith's testimony was that the letters of protection were the basis of his claims to hold Deluca & Maucher responsible. **Ex. M (Dr. Highsmith Depo. Tr. 33:22 – 34:7)**. Plaintiff did not seek leave to amend immediately after Dr. Highsmith's testimony and, instead, waited nearly four months.

Plaintiff also deposed Deluca & Maucher under the original complaint and, in fact, based 26 of the 29 topics on the remaining allegations in the complaint, and Deluca & Maucher's answer and affirmative defenses. **Ex. L**. For example, Plaintiff's first topic was "All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 1 of DeLuca & Maucher's Answer denying the allegations contained in Paragraph 1 of Plaintiff's Complaint. **Ex. L**. The 25 topics following the first one followed the same format. This notice was sent July 12, 2023, and the deposition took place on July 31, 2023. Plaintiff did not move to amend before the deposition or immediately after the deposition.

Finally, Plaintiff did not move to amend until two weeks after Defendants moved for summary judgment. Plaintiff does not explain why the breach of contract action and other claims could not be brought when the complaint was filed when the amendment is based on facts Plaintiff knew before filing, or why it did not seek leave to amend before conducting extensive and costly discovery. The delay is simply inexcusable, and this Court should deny the motion.

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B. Plaintiff should be denied leave to amend because Defendants will be prejudiced by the lack of notice and opportunity to refute the amended allegations.

"Rule 15 prejudice is some result flowing from the amendment that puts the non-moving party at a disadvantage in defending the merits, which disadvantage the party would not have faced if the amended claim had been included in the original pleading or a timely motion to amend." *Patton*, 420 S.C. at 491, 804 S.E.2d at 262-63. The disadvantage, or prejudice, envisioned by the rule, is lack of notice the new issue is to be tried and lack of opportunity to refute it. *Stanley v. Kirkpatrick*, 357 S.C. 169, 174, 592 S.E.2d 296, 298 (2004).

The "lack of opportunity to refute" is met if the nonmoving party shows either (1) it does not have the opportunity to refute the amended claims moving forward because the case is close to trial, or (2) the course of litigation and discovery before the amendment is such that the nonmoving party is foreclosed from refuting the amended claims unless it obtained additional or different evidence. *See, e.g.*, *Holland v. Morbark, Inc.*, 407 S.C. 227, 235, 754 S.E.2d 714, 719 (Ct. App. 2014) (considering one among many reasons for denying leave to amend was that the case was on the eve of trial); *Stanley*, 357 S.C. at 175, 592 S.E.2d at 298 (suggesting the need to retake depositions based on the new facts could result in prejudice from the amendment).

Within the framework of assessing "lack of opportunity to refute" based on previous extensive discovery, prejudice "occurs when the amendment states a new claim or defense [that] would require the opposing party to introduce additional or different evidence to prevail in the amended action." *See generally Weaver v. Lentz*, 348 S.C. 672, 677, 561 S.E.2d 360, 363 (Ct. App. 2002) (quoting *Ball v. Canadian Am. Exp. Co.*, 314 S.C. 272, 275, 442 S.E.2d 620, 622 (Ct. App. 1994)); 6 Wright & Miller, *Federal Practice and Procedure* § 1488 (3d ed. 2010) ("[T]he moving party's failure to include the proposed amendment in the original pleadings may put the

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opposing party to the added burden of further discovery, preparation, and expense, thereby prejudicing the opponent's right to a speedy and inexpensive trial on the merits.").

Along similar lines, prejudice occurs when the amendment would cause significant delay, or impose substantial discovery costs that would have not been necessary if the complaint had been timely amended, considering when need to amend became apparent. *Holland*, 407 S.C. at 235, 754 S.E.2d at 719. For example, in *Holland*, the court of appeals affirmed the circuit court's refusal to grant leave to amend because the amendment would prejudice the nonmoving party by requiring additional discovery and delaying trial. *Id.* The parties had already conducted extensive discovery. *Id.* The court noted that the undertaking of additional discovery did not establish prejudice per se, but the addition of the claim would have required hiring rebuttal experts and taking additional depositions. *Id.* at 236, 754 S.E.2d at 719. The court also considered how the delay and timing of trial enhanced the prejudice, acknowledging the hearing on the motion to amend did not occur until two years after the original complaint was filed, and the moving party was in possession of information alerting him to the relevance of the new claim six months before the hearing on the motion to amend. *See id.* at 235, 754 S.E.2d at 719.

Furthermore, it does not matter for the prejudice analysis that the amendment is not seeking to add a new cause of action; asserting different legal theories is sufficient. *See Holland*, 407 S.C. at 236, 754 S.E.2d at 719 (noting the amendment was not seeking to add a new cause of action, but a new theory would have required additional discovery); *see also Johnson v. Oroweat foods Co.*, 785 F.2d 503, 510 (4th Cir. 1986) (acknowledging prejudice results, in part, if the amendment changes legal theories requiring additional discovery and analysis of facts not previously considered by the nonmoving party). As a result, the *Holland* court found the non-moving party would be prejudiced by the amendment and denied leave to amend. *Id.*

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Here, Defendants did not have notice Plaintiff would be changing legal theories and adding claims and, considering the course of discovery to date, Defendants lack an opportunity to refute the new theories and claims. Regarding lack of notice, Plaintiff pled this case alleging that the contract was based on the Letters of Protection, and that Defendants breached that contract by failing to "protect" claims to the insurance proceeds. Plaintiff's SCUTPA claim is uncertain, but in D&M's deposition, Plaintiff's counsel asked questions signifying the theory was based on the Letter of Protection: asking questions indicating the element for affecting the public interest/capable of repetition is met because Defendants have used Letters of Protection in the past. **Ex. N (D&M Depo. Tr. p. 54-58)**. This would not be applicable if the claim is instead based on representations of coverage limits. Plaintiff continued to litigate this case for over two years under the theories based on the Letters of Protection. Now, Plaintiff wants to change its theories to abandon the Letters of Protection altogether and switch it out with the coverage representations.

Further, Plaintiff's actions for breach of contract accompanied by a fraudulent act, fraud, and constructive fraud were based partially on allegations about the coverage statements and those were dismissed with prejudice by the Court. Thus, the issue about coverage statements serving as a basis for a claim was already decided and did not need to be addressed. Because the Proposed Amended Complaint changes theories of recovery under the breach of contract action and SCUTPA action, and is adding new claims that are very similar to claims already dismissed with prejudice, Defendants had no notice that Plaintiff would make the changes to the complaint it seeks to make. Accordingly, Defendants have shown lack of notice.

Additionally, considering the course of litigation and extent of discovery, Defendants will be deprived of an opportunity to refute the amended allegations. Similar to *Holland*, the parties

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have engaged in extensive discovery under the current pleadings. Plaintiff took the 30(b)(6) deposition of Deluca & Maucher with topics based almost entirely on the current pleadings. Defendants deposed Dr. Highsmith, who was difficult to schedule due to him practicing medicine. These depositions were taken under the pleadings alleging the contract for breach of contract was the Letter of Protection, not that the isolated email from Tina Bennett somehow formed a contract. Had the case been pled as Plaintiff now seeks, Defendants' counsel could have, and would have, addressed the changed theories and new claims in written discovery and depositions. Considering the deposition of any party or witness can only be taken once absent order of the court for good cause shown—Rule 30(a)(2), SCRCP—Defendants cannot retake the deposition of Dr. Highsmith.[3] Because the depositions and written discovery were conducted under Plaintiff's current theory, Defendants would be required to obtain additional and different evidence to oppose the amended theory and new causes of action for negligent misrepresentation and promissory estoppel and, therefore, Defendants would be prejudiced and leave to amend should be denied.

Moreover, the consent scheduling order the parties previously entered into had a discovery deadline of June 5, 2023, "unless additional time is ordered by the Court for good cause shown." Plaintiff cannot show good cause because it was, or should have been, aware of the different theories and additional claims at the time it filed the case, but continued to pursue its current theories even after losing a motion to dismiss and throughout discovery. Without the

[3] To the extent Plaintiff claims it would agree to reopen depositions, Defendants would not agree to reopen the Defendants depositions and doubt Plaintiff would permit second depositions of their witnesses without reciprocation. Additionally, Defendants spent significant time, effort, and money to prepare for and take or defend the depositions. If the Court permits amendment and reopens depositions, Defendants request the Court award Defendants fees and costs associated with the previous depositions. Finally, Defendants submit Plaintiff cannot show good cause to reopen the depositions because, as explained above, Plaintiff had the information necessary to amend the pleadings before all of the depositions, and its delay is inexcusable.

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ability to engage in discovery under the current order, the Defendants would be significantly prejudiced by the change in theories and additional claims.

This Court should also consider Plaintiff's delay in seeking leave to amend, which is similar to that in *Holland*. Here, Plaintiff should have been aware of the amended theories and claims before suit was filed, but did not move to amend until more than two years after suit was filed. Plaintiff was a party to the 2019 email and had it prior to bringing suit, leaving ample time to formulate theories of recovery and specific claims. Despite having the information, Plaintiff chose to base its breach of contract action on the Letters of Protection and continued to pursue those theories throughout discovery after most other causes of action were dismissed. As of the date of this memorandum, Defendants have incurred nearly $70,000 in costs and expenses in defending the suit. Considering Plaintiff's delay, the extensive discovery performed to date, and the additional and different discovery that would be required to meet the amended theories and new claims, Defendants would be prejudiced by the amendment, and this Court should deny Plaintiff's motion for leave to amend.

C. This Court should deny the Motion to Amend because the Amended Order dismissing the majority of Plaintiff's claims prohibits or interferes with Plaintiff's ability to change theories and add new claims.

"This State has a long-standing rule that one judge of the same court cannot overrule another. *Shirley's Iron Works, Inc. v. City of Union*, 403 S.C. 560, 573, 743 S.E.2d 778, 785 (2013). If a ruling is not appealed, whether it is wrong or right, it becomes the law of the case. *Id.* "The doctrine of the law of the case applies to an order or ruling which finally determines a substantial right." *Id.* (quoting *Weil v. Weil*, 299 S.C. 84, 89, 382 S.E.2d 471, 473 (Ct. App. 1989)). If the order, however, merely decides a point collateral to the issues of the case, it is not binding and can be reconsidered before a final order on the merits. *Id.*

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This Court's prior order is the law of the case. It finally decided a substantial right—dismissing the entirety of Plaintiff's claims for (1) breach of contract accompanied by a fraudulent act, (2) fraud, (3) constructive fraud, (4) unjust enrichment and negligence. The claims that were dismissed were based, in part, on allegations related to statements about insurance coverage. **Ex. H**. The order made numerous findings of fact and conclusions of law that Plaintiff has not appealed, and were decided by Judge Dickson. Because the Order ruled on important issues, not collateral issues, and was decided by another judge of the same Court, this Court cannot overrule or modify the Court's Amended Order on the motion to dismiss, and it is the law of the case. The question becomes, then, what effect the rulings will have on the Proposed Amended Complaint.

The Order indicates it will not be "admissible" to prove facts or law for the "remaining claims of Breach of Contract and" SCUTPA. **Ex. H.** Because Plaintiff is changing its theories for breach of contract and, presumably, SCUTPA, those claims are no longer "remaining" and, therefore, this caveat does not apply, and the order will impact the changed claims for breach of contract and SCUTPA. Further, the language limiting the Order's application clearly does not include new claims within that limitation, such as those for negligent misrepresentation and promissory estoppel. Thus, the findings in the Order will be binding on and will impact those new claims.

The Court's Amended Order dismissing Plaintiff's claims will impact Plaintiff's ability to bring new claims and change theories, and risks overcomplicating the case and could lead to conflicting rulings.

The Order makes the findings of fact and conclusions of law below that will impact Plaintiff's Proposed Amended Complaint:

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- "as of January 21, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance." **Ex. H, ¶13.**
- "as of March 7, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance first before seeking payment under the March 7, 2019 LOP." **Ex. H, ¶ 16**.
- "Plaintiff never attempted to confirm its in network status with Client's private health insurance carrier prior to rendering surgical services, or to file claims for payment with Client's private health insurance, as is required under Plaintiff's Financial Policy." **Ex. H, ¶ 17**.
- "On April 29, 2019, D&M notified Plaintiff via email of the foregoing issues" (**Ex. H, ¶ 20**), referring to **Paragraph 19** that states it was determined the at-fault driver did not have sufficient insurance coverage, one policy was inapplicable, and the "additional policy was subject to subrogation only applicable after Client's primary private health insurance had been exhausted."
- Under "Fraud" and "Availability of Insurance Coverage" finding Plaintiff was not entitled, by virtue of the parties' relationship to one another, to rely on Defendants' representations as to insurance coverage or intent to pay. Instead, Plaintiff was under an affirmative duty to use reasonable prudence and diligence to attempt to discovery the truth of the representations." **Ex. H, ¶ 48**.
- "as of January 21, 2019—approximately two (2) months before Client's First Surgery—Plaintiff had actual notice that . . . (2) Defendants did not intend to protect Plaintiff's claims out of any settlement proceeds from Client's personal injury claim; and (3) Plaintiff should file all claims for payment with Client's private health insurance company." **Ex. H, ¶ 52**.
- "Bennett's email to Goodwine did not indicate any claims could or should be filed with Client's underinsured motorist carrier or his occupational accident carrier." **Ex. H, ¶ 53**.
- Plaintiff "should have refused Bennett's instructions to file claims with Client's private health insurance company." **Ex. H, ¶ 54**.
- "Plaintiff should have known the only potential avenue for payment would have been through Client's underinsured motorist and/or occupational accident policies." **Ex. H, ¶ 55**.
- "Plaintiff, in the exercise of reasonable diligence, could and should have taken steps to obtain written confirmations of coverage from the underinsured motorist and occupational accident carriers themselves before furnishing costly surgical and other medical services to Client. **Ex. H, ¶ 56**.
- "Plaintiff apparently instead chose to rely solely on Bennett's first January 21, 2019 email to Goodwine—expressing only an opinion on available coverage—which, as discussed above, Plaintiff had no right to rely on." **Ex. H, ¶ 57**.

Plaintiff's Proposed Amended Complaint alleges four causes of action: (1) breach of contract, (2) SCUTPA violation, (3) negligent misrepresentation, and (4) promissory estoppel.

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The proposed breach of contract action is based on allegations that the parties "entered into a contract wherein Carolina Neurosurgery would provide medical services to the Lawyers' client based on the Lawyers' representations about insurance coverage." **Prop. Amnd. Compl. ¶ 27**. The Order conflicts with Plaintiff's new theory because the Order finds that Plaintiff was on notice as of January 2019 of the need to seek payment from private health insurance, and that Defendants did not intend to protect any claims to insurance proceeds—*after* the statement about insurance proceeds and before any further letter of protection. Further, the Order finds Plaintiff was aware as of April 29, 2019, that the additional policy had a subrogation requirement and required filing with private health insurance first. The Order also clearly states Plaintiff had no right to rely on statements about coverage, and needed to perform its own due diligence about the referenced policies. With these findings in the Order that are the law of the case, Plaintiff cannot now say that a contract was formed, and it provided services because of a statement about coverage in an email that was effectively retracted.

To the extent that Plaintiff's SCUTPA claim relies on statements about coverage, the same findings in the Order are the law of the case and would prevent recovery based on that claim.

Plaintiff's proposed claims for negligent misrepresentation and promissory estoppel are also preempted by the Order. Plaintiff alleges in the negligent misrepresentation claim that Defendants made false representations, and Plaintiff justifiably relied on those representations. **Prop. Amd. Compl. ¶¶ 33, 37**. Plaintiff alleges in its promissory estoppel claim that Defendants gave an "unambiguous promise" and assurances about "the availability of over $1 million in insurance coverage" and that Plaintiff reasonably relied on that promise. The findings in the Order, however, state that Plaintiff did not justifiably rely on statements about coverage.

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Further, the Order states the statement about coverage was an opinion—not a statement of fact. An opinion about insurance coverage cannot also be an unambiguous promise that that coverage was available to pay for medical services. Because those rulings are the law of the case, but Plaintiff would need to prove the opposite to succeed on a claims for negligent misrepresentation and promissory estoppel, the proposed claims are preempted by the Order.

Because the findings in the Order partially granting Defendants' motion to dismiss were made by a different judge in this Court, concern substantial issues that were finally determined and were not appealed, the findings are the law of the case and cannot be changed absent appeal. Because many of those findings are directly contrary to the elements or theories that Plaintiff is asking for leave to assert, it is a significant reason alone to deny the request for leave—either as futility or because allowing the amendment and trial on those new theories could risk confusing the issues. Therefore, this Court should deny the motion to amend.

D. Plaintiff should be denied leave to amend because Plaintiff's delay in seeking leave is contrary to the purpose of Rule 15, and is probative of undue delay, dilatory motive, or bad faith.

Undue delay, dilatory motive and bad faith are proper reasons to deny a motion to amend. *See Patton*, 420 S.C. at 490, 804 S.E.2d at 262; *Forrester v. Smith & Steele Builders, Inc.*, 295 S.C. 504, 506, 369 S.E.2d 156, 158 (Ct. App. 1988). It does not appear our appellate courts have addressed what actions constitute bad faith justifying denial of leave to amend. However, our courts consistently rely upon federal law and treatises interpreting federal Rule 15 to interpret and apply Rule 15 of the South Carolina Rules of Civil Procedure. *See Forrester*, 295 S.C. at 506, 369 S.E.2d at 158 (utilizing J. Moore's *Federal Practice* to interpret Rule 15, SCRCP); *Potomac Leasing Co. v. Bone*, 294 S.C. 494, 497, 366 S.E.2d 26, 28 (Ct. App. 1988) (same); *see also Skydive Myrtle Beach, Inc., v. Horry County*, 426 S.C. 175, 183, 826 S.E.2d 585, 589 (2019)

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(relying on and quoting Wright & Miller's Federal Practice and Procedure section 1487 (3d ed. 2010) to interpret futility under Rule 15, SCRCP). These treatises and federal cases are therefore persuasive for determining what constitutes bad faith warranting denial of leave to amend.

"The function of Rule 15(a) . . . is to enable a party to assert matters that were overlooked or were unknown at the time the party interposed the original complaint or answer." § 1473 Purpose and Scope of Rule 15(a), 6 Fed. Prac. & Proc. Civ. § 1473 (3d ed. 2010). When a court assesses the good faith of the moving party, it considers the reasons for the delay in asserting the amended claims and the timing of when the moving party knew the facts on which the amended matters are based. *Id.* at § 1487.

One who has purposefully delayed asserting a matter contained in an amendment has acted contrary to the spirit and the liberal amendment policy of Rule 15. 6 Wright, § 1448. "By failing to introduce the matter contained in the proposed amendment at as early a stage in the litigation as possible, the pleader has demonstrated bad faith in not apprising the opponent of his true position in the action." *Id.*

Bad faith justifying denying leave to amend has been found in situations where the record established a party was in possession of enough information to support the amendment at an earlier date than the party claimed. *See Febus-Cruz v. Sauri-Santiago*, 652 F. Supp. 2d 166, 169 (D.P.R. 2009); *see also Newport News Holdings Corp. v. Virtual City Vision, Inc.*, 650 F.3d 423, 440 (4th Cir. 2011) (finding spurious a defendant's claim it did not seek to amend earlier because it did not have information to support proposed amended allegations until it received financial information of a party when the proposed amended allegations were not based on the financial information, and affirming the district court's decision to deny leave based, in part, on bad faith).

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Similarly, a request to amend based on newly discovered evidence will not justify an untimely motion to amend the pleadings when the evidence was or could have been discovered earlier. *See Groth v. Orkin Exterminating Co., Inc.*, 909 F. Supp. 1143, 1148-49 (D. Ill. 1995) (finding the party requesting leave based on "newly discovered evidence" could not justify the 18 month delay in moving to amend because the record showed the facts central to the "new claim" were facts the party knew or should have known earlier in the lawsuit, and the party's claim of newly discovered evidence bordered on bad faith and justified denying leave to amend).

For example, in *Febus-Cruz*, which involved a case on an expedited docket, the plaintiff sought to amend the complaint to add a defendant and a claim against a current defendant in his personal capacity. *Id.* The plaintiff claimed it was not aware of the new defendant's involvement until a deposition it took on July 29, 2009. *Id.* The record established, however, that there was information exchanged in discovery in May 2009 showing the new defendant's involvement, and plaintiff had deposed the proposed defendant on June 26, 2009. *Id.* The court concluded the record established the plaintiff should have been in possession of information suggesting the new defendant's role by June 26, 2009, and the plaintiff's assertion it did not have the information until a month later was disingenuous, misleading, and probative of bad faith. *Id.* Accordingly, leave to amend was denied. *Id.* A similar result was reached in *Groth*, which involved a case on a standard docket and the record established the moving party was, or should have been, aware of the facts supporting the amended claims 18 months before moving to amend, contrary to representations to the court that the information was newly discovered. 909 F. Supp. at 1148-49.

Here, as explained above, there was sufficient information in Plaintiff's records that would have alerted it to the potential amended claims and theories earlier than it moved to

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amend, which was more than 2 years after it filed the lawsuit. As in *Febus-Cruz* and *Groth*, the failure to seek an amendment when Plaintiff should have known of the amended allegations/theories 2 years earlier warrants this Court denying Plaintiff leave to amend.

Plaintiff's actions in amending are indicative of bad faith, undue delay, and dilatory motive. Plaintiff has been in possession of the information to make the requested changes since before it filed suit. Yet Plaintiff did not seek to amend its allegations in response to a motion to dismiss, after the motion to dismiss was decided making findings of fact and conclusions of law impacting the remainder of the case, after written discovery, or before allowing Defendants to depose Dr. Highsmith or soon thereafter. Then, despite having the information necessary to amend, Plaintiff took the 30(b)(6) deposition of DeLuca & Maucher based almost entirely on the pleadings at the time, forcing Defendant to prepare for and defend every affirmative defense and denial of allegations in the complaint. Plaintiff did not seek leave to amend until after Defendants moved for summary judgment.

Despite multiple critical events in the life of this case over two years that depend on the allegations in the complaint, Plaintiff did not move to amend until after it knew Defendants were moving for summary judgment. That delay is undue and inexplicable. It violates the policy of Rule 15 to amend the pleadings as soon as possible and is probative of bad faith, justifying denying leave to amend. 6 Wright, § 1448 ("By failing to introduce the matter contained in the proposed amendment at as early a stage in the litigation as possible, the pleader has demonstrated bad faith in not apprising the opponent of his true position in the action.").

The timing and content of the motion to amend also suggests a dilatory motive. Plaintiff filed two weeks after Defendants moved for summary judgment. This timing seems like an attempt to avoid summary judgment by asserting new claims that will need to be litigated.

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Further, notably Plaintiff is no longer including supporting exhibits, perhaps an attempt to avoid the application of Rule 10(c), SCRCP, and an immediate dispositive motion when Defendants' previous dispositive motion succeeded based on the exhibits in the original complaint.

The move away from relying on the Letters of Protection is also telling because Dr. Highsmith's testimony on the Letters of Protection went poorly for the claim. Dr. Highsmith testified he does not notice when letters of protection come in **(Ex. M (15:12-16)**; would treat a patient either way without a letter of protection **(Ex. M (16:13-24))**; does nott know when he read the ones from Defendants but assumes it would have been after Plaintiff was already providing services **(Ex. M (41:1-12; 55:22-56:4))**. Considering Dr. Highsmith's testimony, it is no wonder that Plaintiff wants to completely remove claims based on the Letters of Protection, which indicates an impermissible motive for seeking amendment.

To top it all off, Plaintiff's allegations in the Proposed Amended Complaint are based on a theory that Defendants made false representations about insurance coverage, and primarily the coverage under the $1,000,000 One Beacon policy, and depend on those statements being untrue. *Before* Plaintiff filed its motion to amend, it had received an Explanation of Benefits from One Beacon's successor specifically stating: "The patient is covered under an Occupational Accident Policy. Unless otherwise noted, charges were reduced by the lesser of the usual and customary charge for the service, treatment or supply as reflected in the local Workers' Compensation schedule or negotiated rate." **Ex. O (Explanation of Benefits)**. Although One Beacon's successor reduced the charges to the usual and customary rate, it paid something towards every single service Plaintiff rendered to Client. *Compare* **Ex. O to Ex. F**. By asking this Court to allow an amendment to include allegations that suggest One Beacon did not and would not pay

anything for Plaintiff's medical charges, when Plaintiff knows that is not true, is further indicative of impermissible motive and warrants denying leave.

CONCLUSION

This Court should deny Plaintiff leave to amend because Plaintiff's delay is inexplicable, would cause Defendants prejudice, and is indicative of impermissible motives.

This 14th day of August, 2024.

Respectfully submitted,

COPELAND, STAIR, VALZ & LOVELL, LLP

By: *s/Skyler C. Wilson*
DOUGLAS W. MACKELCAN
State Bar No.: 76332
SKYLER C. WILSON
State Bar No.: 102865
Attorneys for Defendants

40 Calhoun Street, Suite 400
Charleston, SC 29401
dmackelcan@csvl.law
swilson@csvl.law
Ph: 843-727-0307

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EXHIBIT
A

DeLUCA MAUCHER
LAW OFFICES

MICHAEL A. MAUCHER
MIKE@DELUCAMAUCHER.COM
(O) (843) 572-1711 • (F) (843) 572-1285
REPLY TO GOOSE CREEK OFFICE

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December 20, 2018

FAX MAIL
(843) 553-1008

Jason H. Highsmith, M.D.
9313 Medical Plaza Drive, Suite 303
Charleston, South Carolina 29406

RE: My Client: Scott DeMaskey
Date of Accident: 12/14/18

Dear Sir or Madam:

With regard to the above-named individual, please accept this correspondence as our Law Firm's agreement to protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding account balance.

With kindest regards, I am,

Very truly yours,

Michael A. Maucher

MAM/tgb
NOTE: To ensure that this office is aware of your medical lien, please provide an itemized billing statement for services rendered.

DEFENDANT'S EXHIBIT 1 5/19/23 MR Highsmith

****
*** FAX TX REPORT ***
****

TRANSMISSION OK

JOB NO.	4427
DESTINATION ADDRESS	8435531008
SUBADDRESS	
DESTINATION ID	
ST. TIME	12/21 02:12
TX/RX TIME	00' 37
PGS.	1
RESULT	OK

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DELUCA MAUCHER
LAW OFFICES

MICHAEL A. MAUCHER
MIKE@DELUCAMAUCHER.COM
(O) (843) 572-1711 ' (F) (843) 572-1285
REPLY TO GOOSE CREEK OFFICE

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With kindest regards, I am,

Very truly yours,

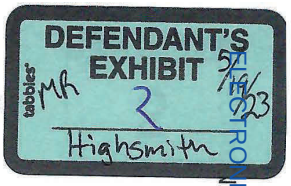
Michael A. Maucher

MAM/tgb

Fax: (843) 474-0712

EXHIBIT B

Fax: (843) 474-0712



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FINANCIAL POLICY

- **BASIC POLICY:** The patient is responsible for medical bills in our office. Our staff will help with completion of insurance forms as an accommodation and convenience to you without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us, and to negotiate with your insurance company over any disputed claims.
- **IF YOU DO NOT HAVE INSURANCE:** Our policy requires payment in full today, unless other arrangements are made. If you cannot pay in full now, we request partial payment today as you arranged for credit on your account with a payment plan agreement with our credit and collection manager.
- **IF YOU HAVE INSURANCE:** Fill out the insurance section of our form, Carolina Neurosurgery & Orthopedics, Inc. does not accept Medicare, Medicaid or any HMO plan. If you are covered by private insurance or PPO with out of network benefits, please present your identification card to the receptionist at the time of your appointment. I understand, as a courtesy, Carolina Neurosurgery & Orthopedics, Inc. will file with my primary insurance. If after 90 (ninety) days from the date of service from the date of service and/or surgery insurance has not paid, the total balance will be considered due and payable. The Medical Providers are out of network and you may be responsible all or part of your balance.
- **WORKMAN'S COMPENSATION:** In the event it is determined by the worker's compensation board that the illness or injury is not a result of a compensable worker's compensation case, I hereby agree to pay the usual and customer fees for the services rendered.
- **REJECTED CLAIMS:** If your insurance company rejects your claim, or if they pay less than the total bill, our policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay your balance in full after your insurance payment, please call Carolina Neurosurgery & Orthopedics, Inc. and make arrangements to pay your bill.
- **FORMS OF PAYMENT:** We accept payments in cash, check, or money order. Checks must be made payable to Carolina Neurosurgery & Orthopedics, Inc.
- **RETURNED CHECKS:** A $100.00 handling charge is applied to all returned checks.
- **DELINQUENT ACCOUNTS:** Delinquent accounts over 90 days are turned over to our collection manager, unless other arrangements are made. If the bill remains unpaid and satisfactory arrangements for payment are not made, the collection manager will review the account with the doctor to decide appropriate legal action including placing a lien on a third-party case. We reserve the right to addition late charges to delinquent accounts requiring collections action and to addition attorney fees, court costs, and/or collections agency fees. If your account is placed with a 3rd party, they have the right to contact you at any number provided to our office.
- **MONTHLY STATEMENTS:** Once your insurance has paid you are responsible for the unpaid balance. You will receive an itemized monthly statement of any patient balance until your bill is paid in full. Interest of 1.5% (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of $0.50 per month.

If this account is assigned to an attorney for collections and/or suit, Carolina Neurosurgery & Orthopedics, Inc. will be entitled to all attorney's fees and costs of collection.

I hereby authorize payment to healthcare provider for all funds owing to me from my case by way of insurance payments, judgment, verdict or other source which may be paid to my attorney or myself.

In addition to my foregoing, in order to secure my obligation to pay the amount of my charges to healthcare provider, and in consideration for healthcare provider's agreements set forth herein, I hereby grant to healthcare provider, in accordance with the uniform commercial code as in effect in the applicable jurisdiction, a security interest in and lien upon: (I) the proceeds; and (II) all proceeds thereof, in each aseptic whether now owned or hereafter existing, acquired or arising, and wherever located. I authorize healthcare provider to file one or more UCC Financing statements (and continuations thereof) naming me as debtor and evidencing healthcare provider's security interest in such collateral. I hereby authorize my attorney to pay healthcare provider from any proceeds of any settlement, if applicable.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure my records to any third party.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and other health plan.

This assignment may not be revoked by me or anyone else. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I have read and agree to the financial policy of this office.

Scott D

Patient Signature

Appointment Date: 1-3-2019

EXHIBIT C

Tina

From: Kiara Goodwine <kiara@orthoandneuro.com>
Sent: Monday, January 21, 2019 12:11 PM
To: Tina
Cc: 'Scott DeMaskey'
Subject: Re: Scott DeMaskey

Okay thanks for the update !

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Tina <Tina@delucamaucher.com>
Sent: Monday, January 21, 2019 11:58:35 AM
To: Kiara Goodwine
Cc: 'Scott DeMaskey'
Subject: Scott DeMaskey

Kiara,

Scott DeMaskey has advised our office that he will require surgery. Based upon the serious nature of his injury, and his pre-existing injuries, we would respectfully request that all of his treatment be filed with his private health insurance company. It would be best for everyone involved if we NOT do the treatment under an Assignment/Letter of Protection.

On a separate matter, please provide this office with the office note and/or documentation which shows the recommended surgery.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

DEFENDANT'S EXHIBIT 5/19/23 Highsmith

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Tina

From: Tina
Sent: Monday, January 21, 2019 9:24 AM
To: 'Klara Goodwine'
Cc: Brooke Dunsil; Kary Garcia
Subject: RE: Scott Demaskey

Kiara,

The at-fault party had a North Carolina Policy of automobile insurance. In order for them to disclosure the limits of their North Carolina Policy, we must provide them with a signed Medical Authorization allowing them to obtain copies of Scott Demaskey's medical records. We are NOT willing to comply with that request. We are therefore unable to find out how much Liability Coverage is on their policy. Because Mr. Demaskey carries $100,000.00 in Underinsured Motorist Coverage on his at-home policy with Safeco, and there is $1,000,000.00 in "Occupational Accident Coverage" to pay bills and wages under the One Beacon Policy, we are not concerned that there will be enough over all coverage to pay the claim.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

From: Kiara Goodwine [mailto:klara@orthoandneuro.com]
Sent: Wednesday, January 16, 2019 4:12 PM
To: Tina
Cc: Brooke Dunsil; Kary Garcia
Subject: Scott Demaskey

Good afternoon,

May I please get limits on patient Scott Demaskey DOB Reda /54

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

Subject: **Fw: Scott Demaskey**
Date: 1/3/2020 2:21:54 PM Eastern Standard Time
From: kiara@orthoandneuro.com
To: edweinberger@aol.com

EXHIBIT D

Thanks, Kiara
Dr. Jason Highsmith
Fax: 843-474-0712
Phone: 843-510-0727

From: Tina <Tina@delucamaucher.com>
Sent: Thursday, March 7, 2019 9:34 AM
To: Kiara Goodwine <kiara@orthoandneuro.com>
Subject: Scott Demaskey

Please see attached LOP. This LOP covers whatever is NOT paid by private health insurance.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

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DEFENDANT'S EXHIBIT 4 5/19/23 MR Highsmith

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DELUCA MAUCHER
LAW OFFICES

MICHAEL A. MAUCHER
MIKE@DELUCAMAUCHER.COM
(O) (843) 572-1711 • (F) (843) 572-1285
REPLY TO GOOSE CREEK OFFICE

March 7, 2019

Jason H. Highsmith, M.D.
9313 Medical Plaza Drive, Suite 305
Charleston, South Carolina 29406

RE: My Client: Scott Demaskey
Date of Accident: 12/14/18

Dear Sir or Madam:

With regard to the above-named individual, please accept this correspondence as our Law Firm's agreement to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding account balance.

With kindest regards, I am,

Very truly yours,

Michael A. Maucher

MAM/tgb
NOTE: To ensure that this office is aware of your medical lien, please provide an itemized billing statement for services rendered.

EXHIBIT E

Carolina Neurosurgery & Orthopedics, Inc.

9313 Medical Plaza, Suite 303
North Charleston, South Carolina 29406
Charleston Office: (843) 510-0727
Fax: (843) 474-0712

161 Medical Cir
West Columbia, South Carolina 29169
Columbia Office (803) 764-1813
Fax: (843) 474-0712

Health Insurance Verification Form For Surgery

MRN #:_____

Patient Name: Scott DeMaskey

DOB: [redacted] SSN: [redacted]

Insurance Company: Blue Cross Blue Shield

ID #: [redacted]

Group#: [redacted]

Please Provide a copy of your insurance card

☐ I do not have Health Insurance at this time

Scott DeMaskey — Patient Name
3-7-2019 — Date

Patient Signature

Kiara Goodwine — Witness
3/7/19 — Date

DEFENDANT'S EXHIBIT 5 5/19/23 MR HighSmith

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EXHIBIT F

Send payment to:
Carolina Neurosurgery and Orthopedics Inc.
2910 Tricom Street, Suite 201
N. Charleston
SC, 29406
Phone No : 843-510-0727 Fax : 843-474-0712

Page: page 1 of 1
Account#: [redacted]
Statement Date: 11/02/2020

TOTAL BALANCE: $125,409.28
(PLEASE PAY THIS AMOUNT)

Bill to:
[redacted] DEMASKEY
[redacted]E
[redacted]

Patient: [redacted] DEMASKEY [redacted]

Date	Description	Charges	Payment	Balance
	You are responsible for the following charges:			
12/20/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
09/06/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
07/18/19	POST OP	0.00	0.00	0.00
07/18/19	XRAY REVIEW	180.00	0.00	180.00
06/13/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
05/24/19	POST OP	0.00	0.00	0.00
05/02/19	[redacted] / [redacted]	62,451.87	0.00	62,451.87
04/26/19	POST OP	0.00	0.00	0.00
04/04/19	POST OP	0.00	0.00	0.00
03/15/19	[redacted]	58,697.41	0.00	58,697.41
03/07/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
01/21/19	EST. PATIENT MOD. HIGH COMPLEX	480.00	0.00	480.00
01/21/19	XRAY REVIEW	180.00	0.00	180.00
01/21/19	[redacted]	300.00	0.00	300.00
01/21/19	[redacted]	300.00	0.00	300.00
01/02/19	NP MOD.HIGH COMPLEX	900.00	0.00	900.00
	TOTAL BALANCE ----->			$125,409.28

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EXHIBIT G

Tina

From: Tina
Sent: Friday, January 03, 2020 1:52 PM
To: 'kiara@orthoandneuro.com'
Subject: Scott DeMaskey

Kiara,

From a review of the updated itemized billing statement you recently provided, it does not appear that Blue Cross Blue Shield has paid any of your bill for services rendered. You may recall that back on:

1. December 20, 2018 we provided your office with a Letter of Protection.
2. January 21, 2019 I emailed you and requested that your office file ALL of Mr. DeMaskey's charges with BCBS due to his extensive pre-existing medical condition.
3. I thereafter emailed you advising that the at-fault party only had $30,000.00 in Liability Coverage and that Mr. DeMaskey's Underinsured Motorist Coverage does not apply.

Even though Mr. DeMaskey's medical bills total $199,744.68, there is only $30,000.00 in available coverage to pay his claim for injury. We will need to figure out a pay to spread those very limited funds around to the medical providers, our office for attorney's fees, and to Scott DeMaskey. In that regard, please confirm the balance owed on Mr. DeMaskey's account.

Thanks,
Tina

Tina G. Bennett
Assistant to Michael A. Maucher
DeLuca & Maucher, LLP
P.O. Box 9
Goose Creek, SC 29445
(843)572-1711 ofc.
(843)572-1285 fax

www.DeLucaMaucher.com

DEFENDANT'S EXHIBIT 12 5/19/23 Highsmith

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EXHIBIT H

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	IN THE NINTH UDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopedics, Inc.,	)	
	)	**AMENDED ORDER ON DEFENDANTS' MOTION TO DISMISS**
Plaintiff,	)	
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	
	)	

THIS MATTER comes before the Court on Defendants' Michael A Maucher, Esq. ("Maucher") and Deluca & Maucher, LLP's ("D&M") (collectively, "Defendants") Motion to Dismiss Plaintiff's Complaint, filed October 22, 2021. The Court heard oral argument on Defendants' Motion on March 3, 2022. The Court granted in part and denied in part Defendants' Motion to Dismiss on June 28, 2022. Plaintiff timely moved to reconsider the Order, which was heard on March 3, 2023. As a result of the hearing and with agreement of counsel, the Court enters this Amended Order on Defendants' Motion to Dismiss.

With Court agreement the parties stipulate that the content of the Order or this Amended Order will not be admissible in this lawsuit to prove or disprove any matter of fact or establish or challenge any conclusion of law with respect to Plaintiff's remaining claims for Breach of Contract and violation of the South Carolina Unfair Trade Practices Act. The Order and Amended Order shall have no effect beyond that of which an order on a motion to dismiss would normally have.

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FINDINGS OF FACT

1. Plaintiff Carolina Neurosurgery & Orthopedics, Inc. ("Plaintiff") is a citizen and resident of Charleston County, South Carolina licensed to practice medicine in South Carolina.

2. Jason M. Highsmith, M.D. ("Highsmith") is Plaintiff's primary surgeon.

3. Maucher is a citizen and resident of Charleston County, South Carolina, and he is an attorney licensed to practice law in South Carolina.

4. D&M is a South Carolina Limited Liability Partnership operating as a law practice with offices in Charleston County and Berkeley County, South Carolina.

5. On December 14, 2018, Defendants' client ("Client") was injured in a motor vehicle collision. Shortly thereafter, he retained Defendants to pursue claims against the at-fault driver.

6. As Client was a prior surgery patient of Plaintiff and Highsmith, he selected Plaintiff for surgical treatment of his injuries arising from the accident. Highsmith performed the procedures.

7. On December 20, 2018, at Client's request, D&M sent Plaintiff a letter of protection ("December 20, 2018 LOP"), in which D&M agreed to protect any claim by Plaintiff for the cost of Client's treatment out of any settlement proceeds arising from the accident. The December 20, 2018 LOP is attached to Plaintiff's Complaint as Exhibit 1 and is incorporated herein by reference.

8. On January 3, 2019, Client executed Plaintiff's Financial Policy ("Financial Policy"), which is attached to Plaintiff's Complaint as Exhibit 2 and is incorporated herein by reference.

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9. The Financial Policy provides that Plaintiff will submit claims for payment under a patient's primary health insurance.

10. On January 16, 2019, Kiara Goodwine ("Goodwine"), an employee in Plaintiff's office, contacted D&M to request information regarding the at-fault driver's liability policy limits. On January 21, Tina Bennett, a paralegal with D&M ("Bennett") responded that the at-fault carrier was from North Carolina and would not disclose policy limits without a medical authorization from Client. However, Bennett informed Goodwine that Client carried a total of $1,100,000 in accident coverage under two additional insurance policies.

11. On the same day, Bennett also emailed Goodwine and informed her that based upon the severity of Client's injury and his pre-existing injuries, all of his treatment would need to be filed with his private health insurance and should not proceed under a letter of protection.

12. Goodwine acknowledged receipt of the email and Bennett's instructions. The foregoing emails are attached to Plaintiff's Complaint as Exhibits 4-5 and are incorporated herein by reference.

13. Accordingly, as of January 21, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance.

14. On March 7, 2019, D&M sent a revised letter of protection to Plaintiff ("March 7, 2019 LOP"), stating that D&M would protect whatever amounts Client's private health insurance did not pay out of the proceeds of any settlement of Client's personal injury claim.

15. Bennett's email containing the March 7, 2019 LOP stated that "[t]his LOP covers whatever is NOT paid by private health insurance." Bennett's email and the March 7, 2019 LOP are attached to Plaintiff's Complaint as Exhibit 6 and are incorporated herein by reference.

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16. As of March 7, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance first before seeking payment under the March 7, 2019 LOP.

17. Despite D&M's prior instructions and the express language of the March 7, 2019 LOP, Plaintiff never attempted to confirm its network status with Client's private health insurance carrier prior to rendering surgical services, or to file claims for payment with Client's private health insurance, as is required under Plaintiff's Financial Policy.

18. Highsmith performed Client's first surgery—a C6-7 ACDF surgery—on March 15, 2019 ("First Surgery") at a cost of $62,451.87.

19. As Client's personal injury case developed, it was determined that: (1) the at-fault driver did not have sufficient insurance coverage to fully cover Client's medical treatment; (2) one of Client's other additional policies was inapplicable; and (3) the other additional policy was subject to subrogation and only applicable after Client's primary private health insurance had been exhausted.

20. On April 29, 2019, D&M notified Plaintiff via email of the foregoing issues, stating:

> "Because the at-fault party only had $30,000.00 and [Client's] Underinsured Motorist Coverage does not apply, ALL of the treatment [Client] has received (and will continue to receive) must be filed under his private health insurance. We cannot honor anymore treatment under a Letter of Protection. Please note [Client's] file accordingly."

21. On May 2, 2019, Highsmith performed additional surgery on Client at an approximate cost of $65,000.00 ("Second Surgery").

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22. Despite receiving explicit instructions regarding claim submission and payment on several occasions prior to both surgeries, Plaintiff never attempted to file claims for Client's surgical services with Client's private health insurance.

23. Instead, Plaintiff waited until around November 2, 2020—almost one year after the completion of Client's treatment—to send Client a bill for surgical services in the amount of $125,409.28. Plaintiff's bill is attached to Plaintiff's Complaint as Exhibit 3 and is incorporated herein by reference.

24. Client has made no payments to Plaintiff for the medical and surgical services provided, and Defendants have not disbursed any funds from the $30,000.00 settlement proceeds recovered for Client.

25. Plaintiff filed this action on July 22, 2021, asserting causes of action against Defendants for: (1) Breach of Contract; (2) Breach of Contract Accompanied by a Fraudulent Act; (3) Violation of the South Carolina Unfair Trade Practices Act; (4) Fraud; (5) Constructive Fraud; (6) Unjust Enrichment; and (7) Negligence.

26. Defendants were served with process on September 24, 2021.

27. Defendants filed their Motion to Dismiss Plaintiff's Complaint on October 22, 2021.

PROCEDURAL STANDARD

When ruling on a Motion to Dismiss pursuant to Rule 12(b)(6), SCRCP, "[t]he circuit court may dismiss a claim when the defendant demonstrates the plaintiff's 'failure to state facts sufficient to constitute a cause of action' in the pleadings filed with the court." *Hambrick v. GMAC Mortg. Corp.*, 370 S.C. 118, 121, 634 S.E.2d 5, 7 (Ct. App. 2006) (*citing FOC Lawshe Ltd. P'ship v. Int' l Paper Co.*, 352 S.C. 408, 412, 574 S.E.2d 228, 230 (Ct.App.2002)). If, in

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viewing the complaint in the light most favorable to the plaintiff, the court determines the facts in the complaint are insufficient to entitle the plaintiff to the relief it seeks, the court should grant the motion. *Baird v. Charleston Co.*, 333 S.C. 519, 527, 511 S.E.2d, 69, 73 (1999).

CONCLUSIONS OF LAW

Based upon the foregoing, the Court makes the following Conclusions of Law:

28. The Court has jurisdiction over the subject matter of this case and the parties hereto.

29. Venue is proper in Charleston County, South Carolina.

I. Plaintiff's Negligence Claim

30. Plaintiff's Complaint fails to allege facts sufficient to support a cause of action for Negligence against Defendants because, as a matter of law, Defendants owed no duty of care to Plaintiff.

31. To establish a cause of action for negligence, a plaintiff must show: (1) the defendant owes a duty of care to the plaintiff; (2) the defendant breached that duty by a negligent act or omission; (3) the defendant's breach was the actual and proximate cause of the plaintiff's injury; and (4) the plaintiff suffered an injury or damages. *Roddey v. Wal-Mart Stores East, LP*, 415 S.C. 580, 589, 784 S.E.2d 670, 675 (2016).

32. The existence of a legal duty is an indispensable element of Negligence. See, e.g., S.C. Elec. & Gas Co. v. Utilities Const. Co., 244 S.C. 79, 88, 135 S.E.2d 613, 617 (1964) ("The breach of a legal duty is essential to negligence…Without a violation of such a legal duty, there is no negligence.").

33. For a duty to arise in the context of an attorney's professional activity, an attorney-client relationship must generally exist between the attorney and the party asserting a

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claim for Negligence. *See Holy Loch Distributors, Inc. v. Hitchcock*, 340 S.C. 20, 26, 531 S.E.2d 282, 285 (2000) (stating that in a legal malpractice and negligence action, a plaintiff must establish, among other elements, "the existence of an attorney-client relationship.").

34. "Generally, "an attorney is immune from liability to third persons arising from the performance of his professional activities as an attorney on behalf of and with the knowledge of his client.' " *Argoe v. Three Rivers Behavioral Center and Psychiatric Solutions*, 388 S.C. 394, 400, 697 S.E.2d 551, 554 (2010) (*citing Pye v. Estate of Fox*, 369 S.C. 555, 564, 633 S.E.2d 505, 509 (2006).

35. Where a plaintiff in a negligence action against an attorney is not the attorney's client, no duty of care exists. *See Argoe*, 388 S.C. at 400, 697 S.E.2d at 554 (holding that the appellant "was not owed a duty of care" because she "was not Respondent's client.").

36. Plaintiff has never been Defendants' client with regard to this matter, nor does its Complaint allege an attorney-client relationship existed between Plaintiff and Defendants. As the Complaint makes clear, Plaintiff is merely a third-party medical services provider that provided surgical treatment for Defendants' Client in the past and that provided additional surgical treatment during Defendants' representation of their Client following his December 14, 2018 accident.

37. Defendants' communications with Plaintiff and its staff were in the course and scope of their representation of Client and pursuit of his personal injury claim against the at-fault driver. *See, e.g.,* December 20, 2018 LOP and March 7, 2019 LOP (identifying Defendants' Client, setting forth the date of Client's accident, and addressing protection of claims Plaintiff may have "out of any settlement proceeds we may receive arising out of [Client's accident]"); Pltf.'s Compl. at Ex. 4, Jan. 21, 2019 email from Tina Bennett to Kiara Goodwine ("[Client] has

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advised our office that he will require surgery. Based upon the serious nature of his injury, and his pre-existing injuries, we would respectfully request that all of his treatment be filed with his private health insurance company.").

38. Plaintiff's Complaint fails to allege any facts to indicate any of Defendants' alleged statements were made outside the course and scope of Defendants' representation of Client.

39. Therefore, because at all relevant times herein Plaintiff was not Defendants' client, and Defendants' statements to Plaintiff were made in the course and scope of their professional activities on behalf of Client and with his knowledge, Defendants did not owe Plaintiff a duty of care as a matter of law.

40. Accordingly, Plaintiff's cause of action for Negligence is dismissed with prejudice.

II. Plaintiff's Fraud and Constructive Fraud Claims

41. Plaintiff's claims for Fraud and Constructive Fraud are subject to dismissal because Plaintiff failed to allege facts sufficient to establish it had a right to rely on the truth of any representations made to it in connection with this matter.

42. "To establish a cause of action for fraud, the following elements must be proven by clear, cogent, and convincing evidence: (1) a representation of fact; (2) its falsity; (3) its materiality; (4) either knowledge of its falsity or a reckless disregard of its truth or falsity; (5) intent that the representation be acted upon; (6) the hearer's ignorance of its falsity; (7) the hearer's reliance on its truth; (8) the hearer's right to rely thereon; and (9) the hearer's consequent or proximate injury." *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 50, 691 S.E.2d 135, 149 (2010).

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43. Further, pursuant to Rule 9(b), SCRCP, "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity." "A complaint is fatally defective if it fails to allege all nine elements of fraud." *Ardis v. Cox*, 314 S.C. 512, 515, 431 S.E.2d 267, 269 (Ct. App. 1993). Where the complaint omits allegations on any element of fraud, the trial court should grant the defendant's motion to dismiss the claim. *Id.*

a. Availability of Insurance Coverage

44. Plaintiff alleges Defendants knowingly or recklessly made false representations of fact as to: (1) "the amount of insurance coverage available to pay for medical/surgical services [Plaintiff] planned to provide to [Client];" and (2) "[Defendants'] intent to pay [Plaintiff] from any recovery [Defendants] obtained on behalf of [Client]." *See* Pltf.'s Compl. at ¶¶ 47-53.

45. However, while Plaintiff generally alleges it had a right to rely on such representations, *See id.* at ¶ 57, its Complaint fails to state with particularity any facts supporting such a right, as required by Rule 9(b), SCRCP and South Carolina case law.

46. "The right to rely must be determined in light of the plaintiff's duty to use reasonable prudence and diligence under the circumstances in identifying the truth with respect to the representations made to him." *Regions Bank v. Schmauch*, 354 S.C. 648, 672, 582 S.E.2d 432, 445 (Ct. App. 2003). "Moreover, there is no right to rely, as required to establish fraud, where there is no confidential or fiduciary relationship and there is an arm's length transaction between mature, educated people. This is especially true in circumstances where one should have utilized precaution and protection to safeguard his interests." *Id*.

47. Here, no confidential or fiduciary relationship existed between Plaintiff and Defendants, and Plaintiff's Complaint does not allege otherwise. Plaintiff was not Defendants' client; it was merely a third-party provider of medical services to Client.

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48. Accordingly, Plaintiff was not entitled, by virtue of the parties' relationship to one another, to rely on Defendants' representations as to insurance coverage or intent to pay. Instead, Plaintiff was under an affirmative duty to use reasonable prudence and diligence to attempt to discover the truth of the representations.

49. Plaintiff alleges that by January 3, 2019—the date on which Client executed Plaintiff's Financial Policy—all parties involved knew Plaintiff and Highsmith were "out-of-network" healthcare providers under Client's private health insurance. Pltf.'s Compl. at ¶ 14.

50. While Bennett initially emailed Goodwine on January 21, 2019 and indicated "we are not concerned that there will be enough overall coverage to pay the claim," *id.* at Ex. 4, she followed up the same day and notified Goodwine that all of Client's surgical treatment was to be filed with his private health insurance company, and that treatment should not proceed under an assignment or letter of protection. *See id*.

51. Goodwine acknowledged receipt of Bennett's instructions and did not indicate there would be any issues with proceeding in the instructed manner. *See id*.

52. Accordingly, the Court finds that as of January 21, 2019—approximately two (2) months before Client's First Surgery—Plaintiff had actual notice that: (1) the December 20, 2018 LOP would no longer be honored; (2) Defendants did not intend to protect Plaintiff's claims out of any settlement proceeds from Client's personal injury claim; and (3) Plaintiff should file all claims for payment with Client's private health insurance company.

53. Further, Bennett's email to Goodwine did not indicate any claims could or should be filed with Client's underinsured motorist carrier or his occupational accident carrier. *See id.*

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54. Assuming, as Plaintiff alleges, that it knew it was an "out-of-network" provider for which claims would not be paid under Client's private health insurance policy, it should have refused Bennett's instructions to file claims with Client's private health insurance company.

55. Further—as of January 21, 2019—because Plaintiff knew Defendants did not intend to protect its claims out of any settlement proceeds, and it allegedly knew there would be no coverage under Client's private health insurance policy, Plaintiff should have known the only potential avenue for payment would have been through Client's underinsured motorist and/or occupational accident policies.

56. Plaintiff, in the exercise of reasonable diligence, could and should have taken steps to obtain written confirmations of coverage from the underinsured motorist and occupational accident carriers themselves before furnishing costly surgical and other medical services to Client.

57. In doing so, Plaintiff could have discovered the potential coverage issues and referred Client to an appropriate "in-network" surgeon for further treatment. However, Plaintiff apparently instead chose to rely solely on Bennett's first January 21, 2019 email to Goodwine—expressing only an opinion on available coverage—which, as discussed above, Plaintiff had no right to rely on.

58. Accordingly—because Plaintiff had no right to rely on Bennett's statement regarding the amount of insurance coverage available to pay for Client's medical and surgical expenses, and Plaintiff's Complaint fails to allege any other efforts undertaken by Plaintiff to protect its interests and discover the truth of the matter—Plaintiff's Fraud and Constructive Fraud claims fail as a matter of law and are hereby dismissed with prejudice.

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b. The Letters of Protection

59. As an initial matter—to the extent Plaintiff asserts claims for Fraud and Constructive Fraud in connection with Defendants' December 20, 2018 LOP, Plaintiff had no right to rely on any statements contained therein because the letter was effectively revoked in Bennett's second January 21, 2019 email to Goodwine stating that treatment should not proceed under a letter of protection.

60. Assuming—for purposes of this Order only—that the March 7, 2019 LOP constitutes a contract by which D&M agreed to "protect any portion of [Plaintiff's] bill not paid by private health insurance out of any settlement proceeds we may receive," then by its terms, Plaintiff was required to seek payment from Client's private health insurance before making a claim to any settlement funds.

61. First, Plaintiff never attempted to submit claims for its services to Client's private health insurance carrier.

62. Second, Plaintiff has failed to allege with particularity any facts or circumstances indicating either that: (1) Defendants had no intention of paying Plaintiff under the March 7, 2019 LOP at the time they sent the letter to Plaintiff; or (2) the statements contained in the March 7, 2019 LOP were false at the time they were made. At most, such statements could possibly be construed as contractual promises of D&M.

63. Without more, Defendants' alleged failure to pay Plaintiff under the March 7, 2019 LOP is insufficient to state valid claims for Fraud or Constructive Fraud. *See Davis v. Upton*, 250 S.C. 288, 291, 157 S.E.2d 567, 568 (1967) ("The general rule is that fraud must relate to a present or pre-existing fact, and cannot ordinarily be predicated on unfulfilled

promises or statements as to future events."). *See also, id.*, 250 S.C. 288 at 293, 157 S.E.2d at 569 (holding that "[t]he mere breach of a contract does not constitute fraud.").

64. Therefore, as Plaintiff's Fraud and Constructive Fraud claims relate to the March 7, 2019 LOP, they are also dismissed with prejudice.

III. Plaintiff's Unjust Enrichment Claim

65. The essential elements of unjust enrichment are: (1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by defendant of the benefit under conditions that make it inequitable for him to retain it without paying its value. *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 15 (Ct. App. 1988).

66. Moreover, speculative claims of future increased value are not a sufficient benefit to support an unjust enrichment claim. *See Bouchard v. Price*, 694 A.2d 670, 673 (R.I. 1997) (holding insufficient "profits that plaintiffs anticipate defendant might obtain by selling the rights to his story at some unspecified time in the future.").

67. Here, Plaintiff alleges it provided surgical services to Client, Pltf.'s Compl. at ¶ 73, and that the provision of such services enhanced the settlement value of Client's claim. *Id.* at ¶74.

68. These allegations are insufficient to support a valid claim for Unjust Enrichment. First, as the Complaint itself admits, Plaintiff provided surgical and other medical services to Client, not to Defendants. Therefore, while Plaintiff clearly conferred a benefit on Client, it did not confer any benefit on Defendants.

69. Second, the potential enhancement in settlement value of Client's claim is too speculative to form the basis of a valid Unjust Enrichment claim. Plaintiff cannot rely on

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conjecture that as a result of its services, at some indeterminate point in the future, Client's claim may have been resolved for a larger amount, or that Defendants would somehow benefit therefrom.

70. Further, Plaintiff has not alleged any facts to show: (1) whether and how the surgical services rendered to Client affected settlement negotiations, if at all; or (2) whether and how Defendants have realized a benefit based on a purported enhancement in settlement value of Client's claim.

71. Accordingly, Plaintiff has failed to plead facts sufficient to show it has conferred any benefit on Defendants, or that Defendants have realized any valid, non-speculative benefit as a result of the surgical services performed for Client. Therefore, Plaintiff's Unjust Enrichment claim is dismissed with prejudice.

IV. Breach of Contract Accompanied by a Fraudulent Act

72. In order to state a claim for Breach of Contract Accompanied by a Fraudulent Act, a plaintiff "must plead facts establishing three elements: (1) a breach of contract; (2) fraudulent intent relating to the breaching of the contract and not merely to its making; and (3) a fraudulent act accompanying the breach." *Harper v. Ethridge*, 290 S.C. 112, 119, 348 S.E.2d 374, 378 (Ct. App. 1986). Plaintiff's claim fails for two primary reasons.

73. First—even assuming the March 7, 2019 LOP is a valid contract and that Defendants' alleged failure to pay Plaintiff constitutes a breach thereof—Plaintiff has failed to allege facts establishing fraudulent intent specifically relating to Defendants' alleged breach of the March 7, 2019 LOP.

74. Plaintiff alleges Defendants breached the March 7, 2019 LOP by refusing to pay it any portion of the $30,000.00 in settlement funds recovered for Client. *See* Pltf.'s Compl. at ¶¶

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35, 39, 40-44. Based on the allegations in Plaintiff's Complaint, it appears Defendants' alleged refusal to pay occurred either in late 2020 or early 2021, after Plaintiff sent Client an invoice for its services on or around November 2, 2020.

75. However, all of Plaintiff's allegations of fraud or fraudulent intent on the part of Defendants relate to Bennett's statements to Goodwine in January, 2019 regarding the availability of insurance coverage. Such statements were made approximately two months prior to the March 7, 2019 LOP.

76. As Plaintiff alleges, "[Defendants] and [Plaintiff] ***entered*** [into] the LOP, with all parties knowing the availability of liability or other insurance coverage was a material term…," *id.* at ¶ 39. Therefore, Plaintiff's allegations relate to the making of the March 7, 2019 LOP, not its alleged breach approximately two years later.

77. Second, Plaintiff has not alleged any fraudulent acts by Defendants accompanying their purported failure to pay Plaintiff under the March 7, 2019 LOP. "[A] fraudulent act is any act characterized by dishonesty in fact, unfair dealing, or the unlawful appropriation of another's property by design." *Harper*, 290 S.C. at 119, 348 S.E.2d at 378.

78. Plaintiff's Complaint contains no allegations of any such dishonest representations of fact, unfair dealing, or unlawful appropriation of property on the part of Defendants.

79. Indeed, as Plaintiff's Complaint admits, "[Defendants] have no explanation on why they have not paid [Plaintiff] the entire $30,000 from the recovery obtained for [Client]." Pltf.'s Compl. at ¶ 39.

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80. At most, the matters alleged in Plaintiff's Complaint may constitute a breach of contract. However, for the foregoing reasons, they are insufficient to support a valid claim for Breach of Contract Accompanied by a Fraudulent Act.

81. Therefore, Plaintiff's claim for Breach of Contract Accompanied by a Fraudulent Act is dismissed with prejudice.

WHEREFORE, it is hereby ORDERED, ADJUDGED, and DECREED that:

A. Defendants' Motion to Dismiss Plaintiff's Complaint is GRANTED as to Plaintiff's claims for: (1) Negligence; (2) Fraud; (3) Constructive Fraud; (4) Unjust Enrichment; and (5) Breach of Contract Accompanied by a Fraudulent Act, and such claims are hereby dismissed with prejudice; and

B. The Court finds Plaintiff has alleged sufficient facts to state a cause of action for: (1) Breach of Contract; and (2) Violation of the South Carolina Unfair Trade Practices Act. Therefore, Defendants' Motion to Dismiss is DENIED as to these claims.

SO ORDERED!

This_____ day of March, 2023.

_____
The Honorable Edgar W. Dickson
First Judicial Circuit

[Electronic Signature Page Follows]

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Charleston Common Pleas

Case Caption: Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al

Case Number: 2021CP1003379

Type: Order/Other

IT IS SO ORDERED.

Edgar W. Dickson

EXHIBIT
I

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopaedics, Inc.,	)	
	)	**CONSENT SCHEDULING ORDER**
Plaintiff,	)	
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	

Pursuant to the South Carolina Rules of Civil Procedure, and upon consent of the undersigned parties who have appeared in this action, this Court establishes the following deadlines in this matter:

1. Mediation shall be completed by no later than February 16, 2023.

2. Discovery shall be completed by no later than **June 5, 2023, unless additional time is ordered by the Court for good cause shown**. All discovery requests shall be served in time for responses to be served by this date. Depositions shall also be completed by this deadline.

3. This case shall not be subject to being called for trial before **September 4, 2023**.

IT IS SO ORDERED!

_____
Chief Administrative Judge
Ninth Judicial Circuit

[*Signature page to follow*]

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I CONSENT:

By: s/Thomas A. Pendarvis
Thomas A. Pendarvis, Esq.
Christopher W. Lempesis, Jr., Esq.
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Counsel for Plaintiff

WE CONSENT:

By: *s/Michael C. Masciale*
Douglas W. MacKelcan: SC Bar No.: 76332
Michael C. Masciale: SC Bar No.: 103819
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Charleston Common Pleas

Case Caption:	Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al
Case Number:	2021CP1003379
Type:	Order/Scheduling Order

So Ordered

s/Jennifer B. McCoy #2764

EXHIBIT
L

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS IN THE NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, Defendants.	**PLAINTIFF'S AMENDED NOTICE OF DEPOSITION PURSUANT TO RULE 30(b)(6), SCRCP** **(DELUCA & MAUCHER, LLP)**

TO: DOUGLAS W MACKELCAN, ESQ. AND SKYLER C. WILSON, ESQ., COUNSEL FOR DEFENDANTS:

PLEASE TAKE NOTICE that Plaintiff, CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., will take stenographic video deposition of Defendant, DELUCA & MAUCHER, LLP ("DeLuca & Maucher"), beginning at 10:00 am on a mutually agreed-upon date, or July 31, 2023, if an agreement cannot be reached for a mutually convenient date, and thereafter by adjournment until the same shall be completed. The deposition will be taken at a mutually convenient location, or at COPELAND, STAIR, VALZ & LOVELL, LLP, 40 Calhoun Street, Suite 400, Charleston, South Carolina, if an agreement cannot be reached for a mutually convenient location.

Pursuant to Rule 30(b)(6), SCRCP, DeLuca & Maucher is required to designate and fully prepare one or more offices, directors, managing agents or other persons who consent to testify on behalf of DeLuca & Maucher and whom DeLuca & Maucher will fully prepare to testify regarding the following designated matters identified beginning on page 6, and as to such information that is known or reasonably available to DeLuca & Maucher's organization. The designated representative should be prepared to identify all documents referenced in any Rule 30(b)(6) topic pursuant to Rule 34, SCRCP, including both written and electronic documents.

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Preliminary Statement / Introduction

DeLuca & Maucher is obligated to produce a knowledgeable witness about the facts, issues, and designations of documents referenced in the Rule 30(b)(6) and Rule 34 portions of this Notice. Complying with Rule 30(b)(6) may require the designation of more than one person to respond to the areas of inquiry stated in this Notice. For the purposes of this Notice and/or the requested deposition, please consider the following precedential cases to be a summary of the requirements applicable to DeLuca & Maucher's corporate designee.

Answers and testimony given by DeLuca & Maucher's designee(s) are binding on DeLuca & Maucher. Covol Fuels No. 4, LLC v. Pinnacle Min. Co., LLC, 785 F.3d 104, 113 n.13 (4th Cir. 2015); Ethox Chem., LLC v. Coca-Cola Co., No. 6:12-CV-01682-TMC, 2014 WL 2719214, at *2 (D.S.C. June 16, 2014) ('It follows that, in order to comply with the rule, the corporation has an affirmative duty to ensure that its designee has knowledge of all information on the noticed topics reasonably available to the corporation and is prepared to provide complete, binding answers on that information.'); Career Counseling, Inc. v. Amsterdam Printing & Litho, Inc., No. 3:15-CV-05061-JMC, 2018 WL 3037106, at *7 (D.S.C. June 19, 2018).

The corporate designee need not have firsthand knowledge of the events in question, but to make the deposition meaningful, the designee must be prepared to provide 'complete, knowledgeable, and binding answers on behalf of the corporation.' Marker v. Union Fidelity Life Inc. Co., 125 F.R.D. 121, 126 (M.D.N.C. 1989); see also In re Vitamins Antitrust Litig., 216 F.R.D.168 (D.D.C. 2003). The designee's preparation should include a review of prior fact witness deposition testimony as well as documents and deposition exhibits, even if that review would be burdensome. Calzaturficio S.C.A.R.P.A. s.p.a. v. Fabiano Shoe Co., Inc., 201 F.R.D. 33, 36-37 (D. Mass. 2001). The primary objective of discovery is to ensure that lawsuits are decided by what the facts reveal, not by what facts are concealed. In Re Anonymous Member of the S.C. Bar, 346 S.C. 177, 193, 552 S.E.2d 10, 18 (2001). In cases where Rule 30(b)(6) depositions are noticed after previous corporate depositions have been taken and the Rule 30(b)(6) notice includes topics partially covered in the previous corporate depositions, the courts have denied motions for protective orders seeking preclusion or limitation on the later

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Rule 30(b)(6) deposition. See e.g., Foster-Miller, Inc. vs. Babcock & Wilcox Canada, 201 F.3d 1 (1st Cir. 2000) (explaining the burden is on company to determine best designee to testify for corporation and prior deposition of corporate fact witness did not preclude Rule 30(b)(6) deposition). The case law is also clear that Rule 30(b)(6) cannot be used to limit what is asked of the designated witness at a deposition. King v. Pratt & Whitney, 161 F.R.D. 475 (S.D. Fla. 1995). The descriptions and/or topics contained within the Rule 30(b)(6) notice simply identifies the minimum to which a witness must be prepared to testify, not the maximum. Detoy v. City & County of San Francisco, 196 F.R.D. 362, 366 (N.D. Cal. 2000); King v. Pratt & Whitney, 161 F.R.D. at 475. Furthermore, under South Carolina law, generally, evidence objected to shall be taken subject to objection. As a rule, instructions not to answer questions at a deposition are improper. See Rule 30(c), SCRCP. Finally, if an examining party were to ask a question arguably outside the scope of the matters described in the Notice, the general provisions of Rule 26(b)(1), SCRCP would apply. ('Parties may object discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action').

Opinions

Rule 30(b)(6) requires that an organization 'must not only testify about facts within [its] knowledge, but also its subjective beliefs and opinions … its interpretation of documents and events.' U.S. v. Taylor, 166 F.R.D. 356, 361-63 (M.D.N.C. 1996) affirmed, 166 F.R.D. 367 (M.D.N.C. 1996).

Knowledge of Organization

Rule 30(b)(6) is intended to prevent serial depositions of various organizational witnesses who do not have the proper knowledge and to eliminate 'bandying,' which is when several people are deposed but each in turn disclaims knowledge of facts that are clearly known to persons in the organization and thereby known by the organization itself. FED. R. CIV. P. 30(b)(6), Advisory Committee Note: 1970 Amendment. '[T]he purpose of a Rule30(b)(6) deposition is to get answers on the subject matter described with reasonable particularity by the noticing party, not to simply get answers limited to what the deponent happens to know.' Alexander v. F.B.I., 186 F.R.D. 148, 152 (D.D.C. 1999). The testimony elicited at the Rule 30(b)(6) deposition represents the

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knowledge of the corporation, not the individual deponents. U.S. v. Taylor, 166. F.R.D. 356 (M.D.N.C. 1996). '[I]f it becomes obvious during the course of a deposition that the designee is deficient, the [organization] is obligated to provide a substitute.' Prokosch v. Catalina Lighting, 193 F.R.D. 633 (D. Minn. 2000).

Duty To Prepare

An organization cannot avoid its Rule30(b)(6) obligations by 'sticking its head in the sand,' refusing to look for the answers, and then saying it does not know the answer. In re Independent Service Orgs Antitrust Litig., 168 F.R.D. 651, 653 (D. Kan.1996). If the representative(s) cannot testify as to the corporation's collective information on the matters requested, then the corporation and/or its attorneys must collect the information and prepare the representative(s) so that the representative(s) can give complete, knowledgeable, and binding testimony. Starlight Int'l Inc. v. Herlihy, 186 F.R.D. 626, 638 (D. Kan. 1999). A thorough, 'reasonable' investigation may require an organization to rely on business records, other documents, interviews with present and former employees and the like. U.S. v. Taylor, 166 F.R.D. at 361. Imposing a duty to prepare its representative(s) ensures that an organization will not ambush an opponent by conducting half-hearted inquiry before the deposition but a thorough and vigorous one before trial. Id. at 362. 'If that preparation means tracking much the same investigative ground that counsel and the risk management / peer review committee have already traversed, but independently of that investigation, so be it.' Wilson v. Lakner, 228 F.R.D. 524 (D. Md. 2005). The company is obligated to produce a knowledgeable deponent who was competently prepared to fully and responsibly address the questions posed by the requesting party. Prokosch v. Catalina Lighting, 193 F.R.D. 633 (D. Minn. 2000). 'DeLuca & Maucher must prepare deponents by having them review prior fact witness deposition testimony as well as documents and deposition exhibits.' Id. Unless it can provide that the information was not known or was inaccessible, a corporation cannot later proffer new or different allegations that could have been made at the time of the 30(b)(6) deposition. Rainey v. American Forest & Paper Assoc., 26 F. Supp. 2d 82 (D.DC. 1998). DeLuca & Maucher will be precluded from offering any testimony at trial on the subjects which its designee was unable or unwilling to testify about at the 30(b)(6) deposition. QBE v. Jorda, 277 F.R.D. 676 (S.D. Fla. 2012).

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Areas of Inquiry

Areas of inquiry seek the discovery of facts and the source of information ... which are clearly relevant and discoverable. BEOC v. Caesars Entertainment, Inc., 237 F.R.D. 428, 434 (D. Nev. 2006). 'A party which intends to assert claims and defenses in litigation must adequately prepare an individual to testify as to those claims and defenses.' In Re Classicstar Mare Lease Litigation, 2009 WL1313311 (E.D. KY. 2009). Discovery of facts and the source of information about the DeLuca & Maucher's claims and defenses, are clearly relevant and discoverable. EEOC v. Caesars Entertainment. Inc., 237 F.R.D. 534, 541 (D. Nev. 2008). 'Clients cannot refuse to disclose facts which their attorneys conveyed to them and which the attorneys obtained from independent sources.' Id. Rule 30(b)(6) cannot be used to limit what is asked of a designated witness at a deposition. Rather, the Rule simply defines a corporation's obligations regarding whom they are obligated to produce for such a deposition and what that witness is obligated to be able to answer. King v. Pratt & Whitney, 161 F.R.D. 475, 476 (S.D. Fla. 1995). Rule 30(b)(6) is not a limitation--30(b)(6) defines minimum, not maximum scope of inquiry—and 26(b)(1) seeks anything leading to relevant information. Id.

No Objection If Difficult To Prepare

An organization cannot simply object to a Rule 30(b)(6) deposition because the required investigation would be 'difficult' or 'time consuming.' Buycks-Robertson v. Citibank Fed. Sav. Bank, 162 F.R.D. 338, 343 (N.D. Ill. 1995). Even if corporate documents are voluminous and the review of those documents would be burdensome, a representative is still required to review them in order to prepare for the deposition; such preparation is necessary because the individuals so deposed are required to testify to the knowledge of the corporation, not the individual. See Calzaturficio S.C.A.R.P.A, s,p.a. v. Fabiano Shoe Co., 201 F.R.D. 33 (D.Mass.2001).

Sanctions

Failure to provide knowledgeable designees who can answer on behalf of DeLuca & Maucher shall be treated as contempt of court pursuant to Rule 37(b), and in such a circumstance DeLuca & Maucher's designee(s)and counsel may be jailed until the matters are testified to properly. Pioneer Drive, LLC v. Nissan, 262 F.R.D. 552 (D.MX. 2009). Preparing a designated witness with only the self-serving half of the story that is the subject of his testimony is not an act

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of good faith. Sciarietta v. Lincoln Nat. Fus. Co., No.13-12559 (11th Cir. 2015). Instructions not to respond that neither shielded a privilege nor supplied time to apply for a protective order were unprofessional and violated the Federal Rules of Civil Procedure as well as the ethical rule. Redwood v. Dobson, 476 F.3d 462 (7th Cir. 2007).

Former Employees

If the corporation no longer employs individuals who have memory of distant events or such individuals are deceased, this still does not relieve the corporation from preparing its designee(s) for the deposition of the corporation to extent matters are reasonably available, whether from documents, past employees, or other sources; while the corporation may plead lack of memory, if it wishes to assert positions based on testimony from third parties, or their documents, the designee still must present opinions as to why the corporation believes the facts should be so construed. U.S. v. Taylor, 166 F.R.D.at 361.

More Than One Designee

The corporation has a duty to designate more than one deponent if it would be necessary to do so in order to respond to the relevant areas of inquiry that are specified with reasonable particularity. Alexander v. F.B.T., 186 F.R.D. 148, 151 (D.D.C. 1999). 'The corporation then must not only produce such number of persons as will satisfy the request, but more importantly, prepare them so that they may give complete, knowledgeable and binding answers on behalf of the corporation.' Marker v. Union Fidelity Life, Inc., 125 F.R.D.121 (M.D.N.C. 1989).

RULE 30 (b)(6) TOPICS

1. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 1 DeLuca & Maucher's Answer denying the allegations contained in Paragraph 1 of Plaintiff's Complaint.

2. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 15 DeLuca & Maucher's Answer denying the allegations contained in Paragraph 15 of Plaintiff's Complaint.

3. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 16 DeLuca & Maucher's Answer denying the

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allegations contained in Paragraph 16 of Plaintiff's Complaint.

4. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 18 DeLuca & Maucher's Answer denying the allegations contained in Paragraph 18 of Plaintiff's Complaint.

5. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 19 DeLuca & Maucher's Answer denying the allegations as stated in Paragraph 19 of Plaintiff's Complaint.

6. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 21 DeLuca & Maucher's Answer denying the allegations contained in Paragraph 21 of Plaintiff's Complaint.

7. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 25 DeLuca & Maucher's Answer denying the allegations as stated in Paragraph 25 of Plaintiff's Complaint.

8. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 37 DeLuca & Maucher's Answer denying the allegations as stated in Paragraph 37 of Plaintiff's Complaint.

9. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 38 DeLuca & Maucher's Answer denying part of the allegations contained in Paragraph 38 of Plaintiff's Complaint.

10. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 41 DeLuca & Maucher's Answer denying the allegations contained in Paragraph 41 of Plaintiff's Complaint.

11. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 43 DeLuca & Maucher's Answer denying the allegations contained in Paragraph 43 of Plaintiff's Complaint.

12. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in Paragraph 49 DeLuca & Maucher's Answer denying the allegations contained in Paragraph 49 of Plaintiff's Complaint.

13. All facts, documents, information, and opinions upon which DeLuca & Maucher

bases its contentions set forth in Paragraph 50 DeLuca & Maucher's Answer denying the allegations contained in Paragraph 50 of Plaintiff's Complaint.

14. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its First Affirmative Defense (Failure to Mitigate Damages).

15. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Second Affirmative Defense (Lack of Mutual Assent).

16. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Third Affirmative Defense (No Acceptance by Plaintiff).

17. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Fourth Affirmative Defense (Failure of Conditions Precedent).

18. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Fifth Affirmative Defense (Abandonment).

19. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Sixth Affirmative Defense (Waiver, Estoppel, and Laches).

20. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Seventh Affirmative Defense (No Causation).

21. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Eighth Affirmative Defense (Limitation of Damages).

22. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Ninth Affirmative Defense (Controlling Person).

23. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Tenth Affirmative Defense (No Adverse Effect on Public Interest).

24. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Eleventh Affirmative Defense (Lack of Willfulness).

25. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Twelfth Affirmative Defense (Frivolous Proceedings).

26. All facts, documents, information, and opinions upon which DeLuca & Maucher bases its contentions set forth in its Thirteenth Affirmative Defense (General Reservation).

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27. All facts, documents, information, and opinions concerning DeLuca & Maucher's relationship with Scott DeMaskey, including each and every client-lawyer relationship and each and every contractual relationship.

28. Any and all agreements or arrangements between DeLuca and Maucher and Scott DeMaskey regarding the lawsuit styled Carolina Neurosurgery and Orthopedics, Inc. v. Scott DeMaskey, Case No. 2021-CP-08-01088 in the Berkeley Court of Common Pleas, including but not limited to agreements for indemnity or hold-harmless.

29. Any and all communications between DeLuca and Maucher and/or its client Scott DeMaskey and One Beacon Specialty Insurance Company or its successors regarding payment under its Occupational Accident insurance policy.

Respectfully submitted,

/s/ Thomas A. Pendarvis
Thomas A. Pendarvis (SC Bar #64918)
Christopher W. Lempesis, Jr. (SC Bar #77012)
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Beaufort, South Carolina
July 12, 2023

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STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC., Plaintiff, vs. Michael A. Maucher, Esq. and DELUCA & MAUCHER, LLP, Defendants.	**CERTIFICATE OF SERVICE**

I, Tracy Lyn Landry, paralegal for Pendarvis Law Offices, P.C., hereby certify that I have served the documents listed below upon all counsel of record by **email only**, to said counsel at the following email address(s):

Douglas W. MacKelcan, Esq.
Skyler C. Wilson, Esq.
COPELAND, STAIR, VALZ & LOVELL, LLP
dmackelcan@csvl.law
swilson@csvl.law

DOCUMENTS SERVED:

- **PLAINTIFF'S AMENDED NOTICE OF DEPOSITION PURSUANT TO RULE 30(b)(6), SCRCP - DELUCA & MAUCHER, LLP.**

Tracy Lyn Landry

July 12, 2023
Beaufort, South Carolina

EXHIBIT
N

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STATE OF SOUTH CAROLINA	) COURT OF COMMON PLEAS
	) NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	) CASE NO. 2021-CP-10-03379
CAROLINA NEUROSURGERY & ORTHOPEDICS, INC.,	)
PLAINTIFF,	)
-VS-	)
MICHAEL A. MAUCHER, ESQ. and DeLUCA & MAUCHER, LLP,	)
DEFENDANTS.	)

CERTIFIED TRANSCRIPT

VIDEOTAPED

30(b)(6)

DEPOSITION OF:

DeLUCA & MAUCHER, LLP

MICHAEL A. MAUCHER

JULY 31, 2023

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apologize on the record for the poor paragraph numbering in the original complaint. There's -- Microsoft and I were just not having a good day.

Anyway, the allegations about Paragraph 49 that we want to talk about is in Paragraph 49 on Page 10 of Exhibit 2. In its answer -- in their answer, the "Defendants admit only that they engaged in trade and commerce in practicing law in the course and scope of their representation of Defendants' client." The remaining allegations are denied. And I want to find out what's the factual basis for the denial of the allegations in Paragraph 49 of the complaint?

A Is that a question?

Q Yes.

A We have not engaged in unfair or deceptive practices, and we have not in our -- obviously, obviously. And then it goes on to say our deceptive acts or practices was willful. That's all denied. That's silly. That baffles me. That is preposterous. That is offensive. And all the facts, as I understand them, we -- we all have the same facts, all the same e-mails.

Q Are you able to identify any specific facts supporting the denial of the allegations in Paragraph 49?

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A That incorporate every statement and every document that we've talked about.

Q Turning to the next topic, which is the -- focuses on the allegations in Paragraph 50 that's -- and the corresponding denial of those allegations in Paragraph 50 of the answer, and Paragraph 50 in the complaint is that "Lawyer's conduct is capable of repetition," and it's been denied. I would like to find out the factual basis for the denial that the lawyers' conduct alleged in this complaint is not capable of repetition.

A All right. So I'm a little confused as where we are. What question on Exhibit No. 1 are we at?

Q The topic of examination is Topic No. 13.

A All right.

Q It's Page 7 carrying over to the top of Page 8. And it refers to Paragraph 50 in Exhibit 2 and Paragraph 50 in Exhibit 3.

A That's denied, correct. It should be denied.

Q It is, and I'm trying to understand the factual basis for denying the statement that the lawyers' conduct is capable of repetition. How is it not capable of repetition?

A This is a fact-dependent circumstance with Mr. DeMaskey going to Carolina Neurosurgery, a place

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where he's gone in the past to be treated by a doctor who's done surgery on him in the past. This is a very unique and singular event in the practice of law.

This case rises and falls on its facts. The fact of the matter is that DeLuca & Maucher, we were not false and deceptive. The fact of the matter is, DeLuca & Maucher, you would have us colluding with Mr. DeMaskey to obtain services and somehow deprive Dr. Highsmith and his practice of being paid. That's furthest from the truth.

If you take a step back and look at it all, we told Dr. Highsmith, "use his Bluecross/Blueshield health insurance so that you get paid." We didn't know that Dr. Highsmith did not take the DeMaskey's Bluecross/Blueshield health insurance. The fact of the matter is, Mr. DeMaskey and Ms. DeMaskey had no idea that Dr. Highsmith and Carolina Neurosurgery did not take his health insurance.

So this is a very specific event, and I think the mistake, if there are any, lies with Carolina Neurosurgery. So as I understand unfair trade practices and fraud and things like that, you have to show that something that's capable of repetition. I think that's like -- once again, I'm not nearly as smart as you or Beth, but I think it's capable of

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repetition's something that happens over and over, and that's just not the case here.

This is just very unique facts and circumstances. I've never run into a doctor -- a surgeon who doesn't take health insurance. I can't say offhand that I've ever run into anybody who's a surgeon. So, no, I don't think it's capable of repetition at all. I think that would be the basis for denying that. And of course, my attorney, who is very smart, might have another explanation for that.

Q We're here today to get D&M's position on it, and it was a properly-noticed deposition. And you're here to give testimony on behalf of D&M. Didn't D&M testify earlier today that this letter of protection attached as Page 2 of Exhibit 6 of the complaint is a standard letter of protection?

A Correct.

Q Didn't that testify earlier?

A Correct.

Q So if it's a standard letter, has it been out -- been issued more than once?

A Right, but I think --

Q No, answer the question. Yes, has it been issued more than once?

A Yes.

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Q How many times, approximately?

A Often.

Q Hundreds?

A Probably more. Thousands.

Q Okay. So if D&M has issued hundreds of these letters of protection, how can it factually claim that this isn't -- this whole series of events is not capable of repetition?

A Easy. Because it says, the letter of protection that we sent, not paid by health insurance. They didn't file health insurance. That was a condition preceding. This is a unique circumstance. And that second letter of protection was sent before any of the surgeries. So, yeah, I stand by it. You may not like the answer, but you have to accept it.

I don't think it's capable of repetition. I think this is a very unique circumstance in which Dr. Highsmith and his office ignored very clear instruction to file the patient's Bluecross/Blueshield insurance from my office and ignored very clear instruction from the patient to file Bluecross/Blueshield insurance. Yeah, I think it's a unique circumstance. So I'm comfortable with the denial that our attorney filed on our behalf.

Q Turning now to Topic 14, identify the facts

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