

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

January 2005 Term

No. 32161

MICHAEL ANGELUCCI,
Plaintiff Below, Appellant

FILED
July 1, 2005
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RORY L. PERRY II, CLERK
SUPREME COURT OF APPEALS
OF WEST VIRGINIA

v.

FAIRMONT GENERAL HOSPITAL, INC.,
Defendant and Third-Party Plaintiff Below, Appellee

v.

NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN,
Third-Party Defendant Below

Appeal from the Circuit Court of Marion County
Honorable Fred L. Fox, II, Judge
Case No. 02-C-282

AFFIRMED

Submitted: May 10, 2005
Filed: July 1, 2005

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The Opinion of the Court was delivered PER CURIAM.

CHIEF JUSTICE ALBRIGHT and JUSTICE STARCHER dissent and reserve the right to file dissenting opinions.

SYLLABUS BY THE COURT

1. “The summary judgment procedure provided by Rule 56 of the West Virginia Rules of Civil Procedure does not infringe the constitutional right of a party to a trial by jury; it is not a substitute for a trial or a trial either by a jury or by the court of an issue of fact, but is a determination that, as a matter of law, there is no issue of fact to be tried.” Syl. pt. 7, *Petros v. Kellas*, 146 W.Va. 619, 122 S.E.2d 177 (1961).

2. “A motion for summary judgment should be granted if the pleadings, exhibits and discovery depositions upon which the motion is submitted for decision disclose that the case involves no genuine issue as to any material fact and that the party who made the motion is entitled to a judgment as a matter of law.” Syl. pt. 5, *Wilkinson v. Searls*, 155 W.Va. 475, 184 S.E.2d 735 (1971).

3. “Although our standard of review for summary judgment remains *de novo*, a circuit court’s order granting summary judgment must set out factual findings sufficient to permit meaningful appellate review. Findings of fact, by necessity, include those facts which the circuit court finds relevant, determinative of the issues and undisputed.” Syl. pt. 3, *Fayette County National Bank v. Lilly*, 199 W.Va. 349, 484 S.E.2d 232 (1997).

Per Curiam:

This action is before this Court upon the appeal of the appellant and plaintiff below, Michael Angelucci, from the March 22, 2004, order of the Circuit Court of Marion County, West Virginia, granting summary judgment in favor of the appellee and defendant below, Fairmont General Hospital, Inc. The controversy concerns the appellant's indebtedness to the Hospital in the amount of \$1,663.80 for cardiac rehabilitation services. In the complaint, the appellant alleged that the Hospital breached a contractual obligation to him by failing to submit the bills for the rehabilitation services to his medical benefit provider and that the Hospital wrongfully and maliciously disclosed the debt to various credit reporting companies. In granting summary judgment for the Hospital, the Circuit Court set forth findings of fact and conclusions of law, thereby confirming the appellant's responsibility to pay the \$1,663.80.

This Court has before it the petition for appeal, all matters of record and the memoranda of law filed by counsel. Upon review, this Court notes that the appellant signed an agreement at the Hospital, prior to receiving treatment, which stated that he would be "directly responsible" for the payment for Hospital services not paid by his medical benefit provider. The appellant received cardiac rehabilitation services at the Hospital and does not dispute the validity or the amount of the resulting debt. Moreover, the Circuit Court determined that the Hospital, in fact, submitted invoices for the services to the appellant's

medical benefit provider. The \$1,663.80, however, was never paid by the provider or by the appellant. Consequently, this Court is of the opinion that the Circuit Court was warranted in granting summary judgment in favor of the Hospital.

Accordingly, the March 22, 2004, order of the Circuit Court of Marion County is affirmed.

I.

Factual and Procedural Background

From September 10, 1997 through December 19, 1997, the appellant, Michael Angelucci, received cardiac rehabilitation services from the appellee, Fairmont General Hospital, Inc., located in Marion County, West Virginia. On the first day, September 10, 1997, the appellant executed an agreement assigning the Hospital his right to benefits from his medical benefit provider for medical services. The agreement also provided that, in the event bills for such services were not paid by the benefit provider or by insurance, the appellant would be “directly responsible.”

At that time, the appellant was a member of the National Association of Letter Carriers (“NALC”) and was entitled to coverage under the NALC Health Benefit Plan. Fairmont General Hospital qualified as a preferred organization under the Plan, and it is

undisputed that coverage was to be provided with respect to the cardiac rehabilitation services received by the appellant.¹

According to the Hospital, four invoices for the appellant's cardiac rehabilitation services, totaling \$1,947.00, were electronically transmitted to the NALC Health Benefit Plan between October 1997 and January 1998. The invoices were in the amounts of \$354.00, \$708.00, \$590.00 and \$295.00 respectively, and copies thereof were sent to the appellant. As the record indicates, NALC received the latter invoice in the amount of \$295.00, and made a partial payment of \$283.20, leaving a total balance due in the amount of \$1,663.80. NALC asserted, however, that it never received the earlier invoices and that, pursuant to the terms of the Health Benefit Plan, it is now too late to pay them. An on-going dispute then ensued between the appellant and the Hospital concerning whether the Hospital had, in fact, submitted the bills to the NALC Health Benefit Plan for payment. Subsequently, the Hospital placed the account with collection agencies, and the debt was disclosed to various credit reporting companies.

In October 2001, the appellant completed a bank loan application to refinance his home. According to the appellant, it was during the processing of the application that he first learned he was mistaken in assuming that the \$1,663.80 debt had been resolved between

¹ The NALC Health Benefit Plan is a federal employees health benefit plan established under the Federal Employees Health Benefit Act. 5 U.S.C. § 8901 (1998).

the Hospital and the NALC Health Benefit Plan. The appellant also learned at that time that the debt had been disclosed to the credit reporting companies. The appellant asserts that, although the bank, Branch Banking & Trust Co. (BB&T), approved the loan, he was denied the optimum interest rate because of the \$1,663.80 debt.²

On October 23, 2002, the appellant filed an action in the Circuit Court of Marion County against the appellee, Fairmont General Hospital, Inc. The complaint set forth three counts alleging: (1) that the Hospital breached a contractual obligation to the appellant by failing to submit the bills for cardiac rehabilitation services to his medical benefit provider, the NALC Medical Benefit Plan, (2) that the Hospital wrongfully and maliciously disclosed the debt to various credit reporting companies and (3) that the appellant is thus entitled to damages and injunctive relief requiring the Hospital to facilitate the removal of the \$1,663.80 debt from the records of the credit reporting companies. The Hospital filed an

² A letter dated March 7, 2003, from BB&T to appellant's counsel stated in part:

We wrote a new mortgage for Mr. Angelucci [in] January, 2002. We were not able to offer him the best "secondary" rate at that time due to some unpaid collections, primarily, one placed by Fairmont General Hospital in the amount of \$1,663. I do not recall the specific obstacles at that time, since I do not have a copy of his loan file.

The bank had previously described the appellant's loan application as "high risk." The appellant's credit reports revealed a number of other unpaid accounts. During his deposition, the appellant explained that many of the bills he had difficulty paying were the result of an illness suffered by his son.

answer denying the allegations of the complaint and the relief requested therein. In addition, the Hospital filed a counterclaim alleging that the appellant is liable for the \$1,663.80 debt.³

Subsequently, the Hospital filed a motion for summary judgment. Following a consideration of the appellant's response and a hearing conducted in January 2004, the Circuit Court granted the motion and entered summary judgment in favor of the Hospital. The order of March 22, 2004, setting forth findings of fact and conclusions of law, states in part as follows:

The Court is of the opinion that it is highly questionable as to whether or not there was a "contract" between Mr. Angelucci and FGH [Fairmont General Hospital, Inc.] regarding the submission of his bills to his insurance carrier [NALC]. Mr. Angelucci cannot recall showing FGH staff his insurance card or completing paperwork to prove an arrangement for FGH to directly submit his medical bills to NALC. * * * On the other hand, FGH did submit Mr. Angelucci's bills to his insurance company for payment. * * * Additionally, when Mr. Angelucci received cardiac services from FGH, he signed the . . . form acknowledging responsibility for any expenses which his insurance company did not pay.

³ In June 2003, the Circuit Court granted the Hospital leave to file a third-party complaint against the NALC Health Benefit Plan to enable the Hospital to seek contribution with regard to the appellant's damage claims. By order entered on January 13, 2004, however, the Circuit Court dismissed the third-party complaint upon the ground that federal preemption barred the Hospital's claim against the NALC Health Benefit Plan. As stated in footnote 1 herein, the NALC Health Benefit Plan is a federal employees health benefit plan established under the Federal Employees Health Benefit Act, 5 U.S.C. § 8901 (1998). No issue concerning the dismissal of the third-party complaint has been raised in this appeal.

Mr. Angelucci has produced no evidence of fraud, intent or malice on the part of FGH and no evidence that FGH knowingly breached any duty to him. * * * Mr. Angelucci acknowledges the debt and that FGH had every right to submit the bills to a collection agency when they remained unpaid. Thus, FGH was under no duty to remove a debt with accurate information from Mr. Angelucci's credit report. * * * Mr. Angelucci's debt was valid, and FGH had a right to take action in its collection of the debt. Furthermore, Mr. Angelucci has provided no proof his credit rating would be higher in the absence of the FGH debt.

II.

Discussion

Pursuant to Rule 56 of the West Virginia Rules of Civil Procedure, summary judgment is proper where the record demonstrates “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.” *Mueller v. American Electric Power Energy Services*, 214 W.Va. 390, 392-93, 589 S.E.2d 532, 534-35 (2003); 11A M.J., *Judgments and Decrees*, § 217.1 (Michie 1997). As this Court explained in syllabus point 7 of *Petros v. Kellas*, 146 W.Va. 619, 122 S.E.2d 177 (1961):

The summary judgment procedure provided by Rule 56 of the West Virginia Rules of Civil Procedure does not infringe the constitutional right of a party to a trial by jury; it is not a substitute for a trial or a trial either by a jury or by the court of an issue of fact, but is a determination that, as a matter of law, there is no issue of fact to be tried.

Syl. pt. 3, *Harrison v. Town of Eleanor*, 191 W.Va. 611, 447 S.E.2d 546 (1994). See also, syl. pt. 7, *Aetna Casualty and Surety Company v. Federal Insurance Company of New York*, 148 W.Va. 160, 133 S.E.2d 770 (1963). Specifically, syllabus point 5 of *Wilkinson v. Searls*, 155 W.Va. 475, 184 S.E.2d 735 (1971), holds:

A motion for summary judgment should be granted if the pleadings, exhibits and discovery depositions upon which the motion is submitted for decision disclose that the case involves no genuine issue as to any material fact and that the party who made the motion is entitled to a judgment as a matter of law.

Syl., *Redden v. Comer*, 200 W.Va. 209, 488 S.E.2d 484 (1997); syl. pt. 1, *Wayne County Bank v. Hodges*, 175 W.Va. 723, 338 S.E.2d 202 (1985).

Upon appeal, the entry of a summary judgment is reviewed by this Court *de novo*. *Redden, supra*, 200 W.Va. at 211, 488 S.E.2d at 486; syl. pt. 1, *Koffler v. City of Huntington*, 196 W.Va. 202, 469 S.E.2d 645 (1996); syl. pt. 1, *Painter v. Peavy*, 192 W.Va. 189, 451 S.E.2d 755 (1994). Nevertheless, as this Court stated in syllabus point 3 of *Fayette County National Bank v. Lilly*, 199 W.Va. 349, 484 S.E.2d 232 (1997): “Although our standard of review for summary judgment remains *de novo*, a circuit court’s order granting summary judgment must set out factual findings sufficient to permit meaningful appellate review. Findings of fact, by necessity, include those facts which the circuit court finds relevant, determinative of the issues and undisputed.” Syl., *Hively v. Merrifield*, 212 W.Va.

804, 575 S.E.2d 414 (2002); syl. pt. 3, *Glover v. St. Mary's Hospital*, 209 W.Va. 695, 551 S.E.2d 31 (2001); syl. pt. 2, *State ex rel. Department of Health and Human Resources v. Kaufman*, 203 W.Va. 56, 506 S.E.2d 93 (1998).

In the action now to be determined, the appellant executed an agreement in September 1997 assigning the Hospital his right to benefits from the NALC Health Benefit Plan for medical services. The agreement also provided that, in the event bills for such services were not paid through such coverage or by insurance, the appellant would be “directly responsible.”⁴ As the agreement stated:

It is understood, whether I sign as agent, patient, or as “Guarantor” that I am directly responsible and will pay for services rendered and not paid by insurance. An assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed a waiver [of] the Hospital’s right to require payment directly from the undersigned or the patient. The Hospital expressly reserves the right to require such payment.

The agreement concluded as follows: “I have read this form and understand its content. I have had an opportunity to ask questions which have been answered to my

⁴ Although the National Association of Letter Carriers and the NALC Health Benefit Plan do not constitute an insurance company, the coverage provided by the Plan and the term *insurance* are considered equivalent for purposes of this action.

satisfaction.” During his subsequent deposition, the appellant acknowledged his ultimate responsibility to pay the Hospital for the cardiac rehabilitation services.⁵

Here, neither the validity of the debt nor the amount thereof are in dispute. As stated above, the original amount payable, \$1,947.00, was reduced to \$1,663.80 through the \$283.20 payment made by the NALC Health Benefit Plan. Importantly, the Circuit Court indicated that NALC had received all the invoices relating to the debt. As the March 22, 2004, order states: “FGH did submit Mr. Angelucci’s bills to his insurance company for payment.” That determination is supported by the affidavit of the Hospital’s Director of Patient Accounting filed in the Circuit Court. The affidavit states in part:

⁵ In his September 10, 2003, deposition, the appellant testified as follows:

Q. Just so that our record is complete and accurate as I can make it. At the time you went to Fairmont General Hospital for your cardiac rehab services, you knew that there would be charges for those services?

A. Yes, sir.

Q. You went there because you wanted your insurance company to pay as much as possible toward those expenses?

A. That’s true.

Q. Nonetheless, you also understood that these charges that were being incurred at Fairmont General Hospital were for your benefit and they were your responsibility to pay?

A. Yes, sir.

FGH electronically submitted invoices to NALC for services rendered to the [appellant] on a monthly basis by downloading invoices from its medical billing system, MEDITECH, to an electronic billing system, QUADAX.

QUADAX then electronically forwards claims to the respective clearinghouse used by NALC.

FGH tracks the submission of invoices through its MEDITECH computer system, which automatically creates a log of transactions once they are electronically forwarded to QUADAX for submission to NALC or any other insurance company.

Based upon the record automatically created by MEDITECH, FGH submitted four invoices for the [appellant's] cardiac rehabilitation services to QUADAX for submission to NALC: (1) a claim dated 9/30/97, submitted 10/01/97 in the amount of \$354.00; (2) a claim dated 10/31/97, submitted on 11/03/97 in the amount of \$708.00; (3) a claim dated 11/30/97, submitted on 12/01/97 in the amount of \$590.00; and (4) a claim dated 12/31/97, submitted on 01/01/98 in the amount of \$295.00.

The assertion of NALC that it did not receive the invoices, notwithstanding, an examination of the record reveals no basis for overturning the finding of the Circuit Court that the invoices were submitted to NALC for payment. The \$1,663.80 never having been paid by either the NALC Health Benefit Plan or the appellant, the appellant's complaint was without justification in alleging that the Hospital wrongfully and maliciously disclosed the

debt to the credit reporting companies. Consequently, the Circuit Court was warranted in granting summary judgment in favor of the Hospital.⁶

⁶ In so holding, this Court is not unmindful of the serious harm which can result to individuals from the wrongful or malicious disclosure of accounts to credit reporting companies. *See*, syllabus point 2 of *Jones v. Credit Bureau of Huntington*, 184 W.Va. 112, 399 S.E.2d 694 (1990), concerning the federal Fair Credit Reporting Act.

In this action, however, the validity and the amount of the debt were not in dispute, and the appellant's "direct responsibility" to pay the debt was evidenced by the agreement he signed in September 1997.

III.

Conclusion

Upon all of the above, the March 22, 2004, order of the Circuit Court of Marion County, West Virginia, granting summary judgment in favor of the appellee, Fairmont General Hospital, Inc., is affirmed.

Affirmed