APPELLATE CASE SUMMARIES

By **H. Thomas Watson**

Horvitz & Levy, LLP

By **Peder K. Batalden**

Horvitz & Levy, LLP

CASE NOTES

Prepared by H. Thomas Watson
and Peder K. Batalden
Horvitz & Levy, LLP

Supreme Court's O.B. decision does not alter review of administrative decisions

Yazdi v. Dental Board of California (Nov. 3, 2020, B298130) __ Cal.App.5th __ [2020 WL 6440798]

The Dental Board of California filed an accusation against orthodontist Mohammadrez Yazdi, charging that he had failed to comply with its subpoenas seeking dental records of numerous patients and that he had failed to pay administrative fines. Following a 10-day evidentiary hearing, an administrative law judge ruled that the Dental Board had proven some (but not all) accusations by clear and convincing evidence. The Dental Board adopted the judge's decision and recommended discipline, revoking Yazdi's dental license but staying the revocation and placing him on probation for five years. Yazdi petitioned the superior court for a writ of administrative mandate. After reviewing the Board's decision under the "independent judgment" standard, the trial court denied the petition and upheld the Board's decision.

On appeal, Yazdi argued that, based on *Conservatorship of O.B.* (2020) 9 Cal.5th 989, the trial court should have taken into account the clear and convincing evidence standard in reviewing the Board's decision, rather than applying the "independent judgment" standard. The Court of Appeal disagreed, holding that "the *O.B.* decision is not apposite to the administrative mandate setting." *O.B.* supplies guidance for appellate review "where the trial court was the original finder of fact in a contested proceeding, and the 'clear and convincing' standard of proof applied to particular findings made by the trial court." An appellate court evaluating such findings must incorporate the clear and convincing evidence standard into its review. A trial court does not engage in appellate review of an agency decision when ruling on a petition for writ of administrative mandamus, however. Unlike an appellate tribunal, under the independent judgment rule, "the trial court must weigh the evidence and make its own determination as to whether the administrative findings should be sustained." The appellate court then reviews the decision of the trial court—not the agency decision—under the substantial evidence standard. Thus, the proposition established in *O.B.* does not come into play when superior courts engage in writ review of agency decisions. After rejecting Yazdi's procedural argument, the Court of Appeal ruled against him on the merits (identifying substantial evidence that supported the trial court's findings), and affirmed the discipline imposed by the Dental Board.

Mental health parity laws do not require ERISA plans to cover all medically necessary mental illness treatment

Stone v. UnitedHealthcare Ins. Co., __ F.3d __, 2020 WL 6556332 (9th Cir., Nov. 9, 2020)

Suzanne Stone had a health care plan governed by ERISA. Stone's daughter received in-state treatment for an eating disorder that was approved by the plan administrator, but was discharged with a referral to a facility in Colorado offering a higher level of care. The ERISA plan excluded coverage for health services rendered "outside the service area" of California. Stone enrolled her daughter at the Colorado facility, then sued the plan administrator for denying coverage and disadvantaging treatment for mental illness. The district court granted the administrator's motion for summary judgment, ruling that the plan's limitation of coverage to California was valid because it applied equally to mental *and* physical health services. Stone appealed.

The Ninth Circuit affirmed, rejecting Stone's contention that California Parity Act guarantees a substantive right to medically necessary treatment of listed mental illnesses. The court explained that the Act requires plans to cover medically necessary treatments of mental illnesses (including eating disorders) under the same terms and conditions of other medical conditions. Similarly, the Federal Parity Act requires plans to have benefit limitations for mental health issues that are "no more restrictive" than those for other medical issues. Here, the plan administrator violated neither act because the plan's geographic limitation applied equally to all health treatments. The Court explained that excluding

coverage of the out-of-state treatment was not an improper denial of an entire type of medically necessary treatment; rather, it was a proper threshold condition of plaintiff's plan that applied equally to all benefits.

Payment by Medicare is not a prerequisite for suing to enforce the Medicare as Secondary Payer (MPS) provisions

DaVita Inc. v. Virginia Mason Mem'l Hosp., __ F.3d __, 2020 WL 6887341 (9th Cir. Nov. 24, 2020)

Persons with end-stage renal disease (ESRD) become eligible for Medicare after three months of dialysis treatment, even if not otherwise eligible for Medicare. The Medicare as Secondary Payer provision (MSP), 42 U.S.C. § 1395y(b), dictates who pays first and who pays second when both Medicare and an insurer have independent obligations to pay for a service such as dialysis. The MSP also imposes certain requirements on group health plans, such as forbidding plans from taking into account an ESRD patient's eligibility for Medicare during the first thirty months of Medicare eligibility.

Defendant Virginia Mason Memorial Hospital administers its own group health plan that authorizes payment to providers of dialysis. Plaintiff DaVita, Inc., provides dialysis treatment to patients, including a beneficiary of Virginia Mason's group health plan with ESRD. DaVita sued the Virginia Mason Plan under the MSP's private cause of action provision, alleging that it failed to make statutorily compliant primary payments because it reduced payments as soon as patients became eligible for Medicare without waiting the mandatory thirty months. However, because the reduced payments were more than the Medicare rate, Medicare never made any secondary payments. The district court dismissed the complaint, holding that a private cause of action is available only when Medicare has made a payment. DaVita appealed.

The Ninth Circuit reversed. Expressly disagreeing with two Sixth Circuit decisions, *DaVita, Inc. v. Marietta Mem'l Hosp. Empl. Health Benefit Plan*, 978 F.3d 326, 337-40 (6th Cir. 2020), and *Bio-Medical Applications v. Tenn., Inc. v. Central States Se. & Sw. Areas Health & Welfare Fund*, 656 F.3d 277, 278 (6th Cir. 2011), the Ninth Circuit held "that Congress did not intend payment by Medicare to be a prerequisite to bringing a private cause of action under the MSP." Thus, an MSP claim is available when a primary plan impermissibly takes Medicare eligibility into account too soon, even if Medicare has not made payments. The Ninth Circuit explained that the private right of action attaches if a plan *either* fails to pay the same for Medicare enrollees *or* fails to pay first when required to do so. The plan need not fail on both scores; a noncompliant payment, for either reason, triggers the right to sue.

Group health plan does not violate the Medicare as Secondary Payer (MSP) provisions when it reimburses dialysis services at the same rate, regardless of underlying diagnosis or Medicare eligibility

DaVita Inc. v. Amy's Kitchen, Inc., __ F.3d __, 2020 WL 6887338 (9th Cir. Nov. 24, 2020)

The Medicare as Secondary Payer provisions (MSP), 42 U.S.C. § 1395y(b), dictate who pays first and who pays second when both Medicare and an insurer have independent obligations to pay for a service such as dialysis. Those provisions also forbid plans from taking into account an end-stage renal disease (ESRD) patient's eligibility for Medicare during the first thirty months of Medicare eligibility.

Plaintiff DaVita, Inc., provides dialysis treatment to patients with ESRD, including a beneficiary of Amy's Kitchen's Employee Benefit Health Plan (Amy's Plan). DaVita sued Amy's Plan, alleging that its dialysis payment provisions violate the MSP, ERISA, and state law. The district court dismissed the federal claims and declined to exercise supplemental jurisdiction over the state-law claims. The court rejected DaVita's MSP claim because the plan reimburses at the same rate for all dialysis services regardless of underlying diagnosis or Medicare eligibility. DeVita appealed.

The Ninth Circuit affirmed, holding that Amy's Plan did not violate the MSP because it uniformly reimburses all dialysis treatments. The court explained that the MSP prohibits a plan from taking into account whether an individual is eligible for or enrolled in Medicare and prohibits a plan from "differentiat[ing] in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner." Expressly disagreeing with the *Sixth Circuit in DaVita, Inc. v. Marietta Mem'l Hosp. Empl. Health Benefit Plan*, 978 F.3d 326, 350-51 (6th Cir. 2020), the Ninth Circuit rejected DaVita's claim that the MSP goes further and bars provisions that have a disproportionate effect, or disparate impact, on persons with ESRD. According to the Ninth Circuit, Congress did not intend to prohibit plans from offering benefits that disproportionately impact persons with ESRD, unless they restrict benefits for treatments that are *exclusively* for ESRD patients.

Eliminating community pharmacies from health plan violated the ACA anti-discrimination provision by disparately impacting AIDS/HIV patients

Doe v. CVS Pharmacy, __ F.3d __, 2020 WL 7234964 (9th Cir. Dec. 9, 2020)

Individuals with HIV/AIDS who rely on an employer-sponsored health plan for their medication sued their pharmacy benefits manager, CVS Caremark, alleging that its modification of the pharmacy benefits program violated the anti-discrimination provisions of the Affordable Care Act (ACA), Americans with Disabilities Act (ADA), and California's Unruh Act, denied benefits that were owed under ERISA, and violated California's unfair competition law (UCL). Prior to CVS's modification, plaintiffs could refill their prescriptions at community pharmacies, where they could consult the pharmacist regarding drug interactions and make modifications needed to address disease progression. Following the modification, however, HIV/AIDS drugs and other specialty medications had to be obtained by mail or drop shipment to CVS pharmacy stores, while non-specialty prescriptions could be filled at any community pharmacy and still remain "in-network." Plaintiffs alleged the modification caused them to lose essential counseling their local pharmacies provided, created difficulty in obtaining refills, risked drug interaction problems because different medications had to be filled at different

pharmacies, and increased the risk of disclosing their private medical information. The district court dismissed the complaint with prejudice, and plaintiffs appealed.

The Ninth Circuit vacated in part and affirmed in part. First, the Court held that the ACA did not create a healthcare-specific anti-discrimination standard; instead, it incorporated anti-discrimination standards from numerous civil rights statutes, including the ADA and Title VII of the Civil Rights Act. Applying these principles, the Court held that, under the Rehabilitation Act, the plaintiffs adequately alleged that CVS's modifications disparately impacted HIV/AIDS patients and denied them meaningful access to their prescription drug benefit because of "their unique pharmaceutical need[s]," including medically appropriate dispensing of medications and access to necessary counseling. The fact the program applied to enrollees in a facially neutral way did not negate plaintiffs' disparate impact discrimination claim. But the Court rejected plaintiffs' ADA claim because their benefit plan is not a place of "public accommodation," and the Court rejected plaintiffs' ERISA claim because they failed to identify a specific term in their healthcare plan that conferred the benefits they claim were denied. Finally, the Court partially reversed dismissal of plaintiffs' UCL claim because they adequately stated a Rehabilitation Act-based discrimination claim under the ACA (upon which a UCL claim could be premised), but the Court affirmed dismissal of the UCL claim based on alleged "unfairness" of CVS Caremark's decision to modify the pharmacy benefits in order to increase profits.

Inferences based on hospital staff's custom and practice are insufficient to prove that a patient authorized relatives to execute arbitration agreements on his behalf

Garcia v. KND Development 52, LLC (Dec. 15, 2020, B301929) __Cal.App.5th__ [2020 WL 7351173]

Ramiro Garcia was admitted to Kindred Hospitals for treatment. Following his death, Garcia's widow, Maria, sued the hospitals for negligence, elder abuse, and wrongful death. The hospitals moved to compel arbitration based on two agreements, one signed by Ramiro's son, Mike, another signed by Maria. The hospitals argued that Mike and Maria were Garcia's ostensible agents with authority to execute the arbitration agreements, along with other admitting documents. The hospitals' motion was supported by declarations of hospital staff regarding their inference that Garcia had authorized his relatives to execute the arbitration agreements based on their custom and practice during the admission process. No hospital declarant described the actual circumstances of Garcia's admissions, or averred that Garcia had authorized Mike or Maria to execute an arbitration agreement on his behalf. The trial court denied the motion to compel arbitration, ruling that the hospitals failed to meet their burden of establishing that Garcia authorized Mike and Maria to execute the arbitration agreements on his behalf. The hospitals appealed.

The Court of Appeal affirmed, holding that substantial evidence supported the trial court's finding that the hospitals failed to prove Garcia has authorized Mike and Maria to execute arbitration agreements on his behalf. The court explained that the only evidence of authorization was inferences made by declarants, and the trial court was not compelled to accept them. Additionally, in their declarations, Mike and Maria controverted the accounts of the hospitals' declarants, and the trial court could reasonably accept the truth of their declarations. Finally, the Court rejected the hospitals' argument that the trial court was compelled to accept evidence upholding the arbitration agreements under *Kinder Nursing Centers Ltd. Partnership v. Clark* (2017) __ U.S. __, 137 S.Ct. 1421. The Court of Appeal explained that Kinder construed the Federal Arbitration Act as preempting state laws that discriminate against arbitration agreements, but Kinder nonetheless allows courts to invalidate arbitration agreements based on generally applicable contract defenses that do not discriminate against arbitration. Because the scope of the authority possessed by an agent executing an agreement presents a contractual question that is neutral as to arbitration, the trial court's ruling was consistent with the FAA.

Medical group's proprietary "Relative Value Unit" assessment of physician performance and productivity may be protected as a trade secret

Coast Hematology-Oncology Associates Medical Group, Inc. v. Long Beach Memorial Medical Center (Dec. 15, 2020, B297984) __Cal.App.5th__ [2020 WL 7351233]

Long Beach Memorial Medical attempted to buy Coast Hematology-Oncology Associates Medical Group, Inc., but the parties were unable to agree on terms. Memorial then hired two doctors and four staff members away from Coast. Coast responded by suing Memorial for misappropriation of trade secrets and related tort claims. Memorial successfully moved for summary judgment, and Coast appealed.

The Court of Appeal reversed in part, holding there was a triable issue whether Coast could assert trade secret protection regarding its historical "Relative Value Unit" (RVU) assessment of physician performance and productivity. RVU is a nationally uniform quantitative scale rating the difficulty of various medical services, and widely available information generally cannot be a protected trade secret. But the court held that historical data regarding Coast's application of that scale to its physicians could be valuable if Coast took reasonable effort to maintain the secrecy of that physician productivity information. The court also held that firm-wide productivity data can qualify for trade secret protection, even if individual employees have the right to disclose their portion of that firm-wide data.

However, the court affirmed summary judgment regarding Coast's claimed trade secret regarding its use of "Current Procedural Terminology" (CPT) codes—a nationally uniform medical billing code system—since Coast failed to timely identify with reasonable particularity any CPT secrets. (See Code Civ. Proc., § 2019.210.) The court rejected Coast's argument that it should have been granted leave to amend its identification after Memorial filed its summary judgment motion, reasoning that a plaintiff cannot "wait until the defense has loosed its arrow at the bullseye, then move the target, and finally claim victory when the defense's arrow misses the mark."

Provider, who falsely billed for a speech pathologist who provided no services, was properly convicted of identity theft

United States v. Harris, __ F.3d __, 2020 WL 7705577 (9th Cir. Dec. 29, 2020)

Shelia Harris, who had a government contract to provide therapeutic health services to program members, submitted claims seeking payment for a speech pathologist who provided no services. The claims included the pathologist's name and unique National Provider Identifier number. The pathologist was not aware of Harris's fraudulent billing. Harris was charged with wire fraud and identity theft under 18 U.S.C. § 1028A, which criminalizes the knowing "use" of another's means of identification, without their permission, "during and in relation" to the commission of an enumerated felony, including wire fraud. After Harris was convicted on all counts, she appealed the identity theft conviction, contending that she did not "use" the doctor's identification "during and in relation to" the commission of the wire fraud.

The Ninth Circuit affirmed, holding Harris's conduct met the definition of "use" under § 1028A because she exploited the doctor's identification to "further or facilitate" the wire fraud. The court distinguished decisions holding that misrepresentations regarding the type of treatment performed do not support an identity theft claim. In those cases, neither the practitioner nor the patient had been misidentified. Drawing an analogy to cases involving the impersonation of a practitioner, the court then held that the definition of "use" under § 1028A was broad enough to encompass Harris's misuse of the doctor's identification to claim reimbursement for services that the doctor never performed because that misrepresentation furthered and facilitated the wire fraud.

MICRA statute of limitations runs from when a patient reasonably should notice that an undiagnosed condition has developed into a more serious condition

Filosa v. Alagappan (Dec. 21, 2020, A156412) __Cal.App.5th__ [2020 WL 7640128], certified for publication Jan. 8, 2021

Plaintiff Michael Filosa underwent an MRI in September 2010 after years of suffering severe and worsening headaches. Dr. Ravi Algappan, a radiologist, interpreted the MRI results and found no abnormalities. Filosa's headaches continued to worsen, and he began suffering other adverse physical and mental challenges. In 2014, he underwent brain imaging that revealed a brain cyst or tumor. A new review of the 2010 MRI showed that a "relatively subtle" mass already existed at that time. Filosa sued Dr. Algappan for medical malpractice in March 2016 (after serving notice of intent to sue in November 2015) based on his failure to diagnose the brain mass in 2010. The trial court granted Dr. Algappan's motion for summary judgment, ruling that Filosa's lawsuit was barred by the MICRA statute of limitations (Code Civ. Proc., § 340.5). Filosa appealed.

The Court of Appeal reversed. The court explained that section 340.5 required Filosa to file his medical malpractice action "on the earlier date of three years after his injury or one year after he discovered [or reasonably should have discovered] the injury, plus 90 days under section 364, subdivision (d)." Because "the same 'injury commences both the three-year and the one-year limitations periods,' " identifying the date when Filosa's "injury" occurred is crucial. When a plaintiff brings a malpractice action based on the defendant's failure to diagnose a latent, progressive condition, an "injury" occurs when the plaintiff either notices or reasonably should notice that the undiagnosed condition has developed into a more serious condition. Here, although Filosa's headaches steadily worsened over many years, a jury could reasonably find that this was a continuation of an existing condition, not a manifestation of a more serious condition. Moreover, the jury could reasonably infer that any increase in symptoms was due to other events disrupting Filosa's life, including a divorce, solo child care, the need for mental health services to combat stress and depression, and declining job performance. Finally, although Filoso continued to express concern about a possible brain tumor, his physician dismissed that concern. Under the circumstances, "a patient's concerns or suspicions about the diagnosis do not trigger the statute of limitations when no more serious condition is manifest and no lack of diligence is shown." Thus, the undisputed facts did not conclusively establish the appearance of a more serious condition that would trigger the three-year MICRA statute of limitations, nor did they establish that Filosa was on notice of (or should have discovered) his injury and its negligent cause more than one year before he filed his complaint.

"Virtual Presence" by Real-Time Livestreaming Satisfies the Contemporaneous Presence Requirement for a Bystander NIED Claim

Ko v. Maxim Healthcare Services, Inc. (2020) 58 Cal.App.5th 1144

Plaintiffs brought claims for negligence and negligent infliction of emotional distress (NIED), alleging a vocational nurse who worked as an in-home caregiver for plaintiffs' disabled son abused him while plaintiffs were away. Plaintiffs alleged they witnessed the nurse abusing their son in real time as they watched the livestream of video and audio on their smartphone from a camera in the home. The trial court ruled that plaintiffs could not state a cause of action for NIED as bystanders because they were not physically present when the abuse occurred and thus could not satisfy the requirement of being "present at the scene of the injury-producing event at the time it occurs and . . . then aware that it is causing injury to the victim." (See *Thing v. La Chusa* (1989) 48 Cal.3d 644, 688.)

The Court of Appeal reversed, holding that plaintiffs' "virtual presence" during the abuse through a real-time audiovisual connection satisfied the requirement of contemporaneous presence. The court reasoned that technology for virtual presence has developed dramatically since the Supreme Court decided *Thing* and it is now common for families to experience events as they unfold through livestreaming of video and audio. "Where plaintiffs allege they were virtually present at the scene of an injury-producing event sufficient for them to have a contemporaneous sensory awareness of the event causing injury to their loved one," they satisfy the contemporaneous presence requirement for NIED.

Hospital that miscalculated "a relatively simple" deadline cannot rely on equitable tolling to save its untimely writ petition

Saint Francis Memorial Hospital v. State Department of Public Health (Jan. 13, 2021, A150545) __ Cal.App.5th __ [2021 WL 115994]

Saint Francis Memorial Hospital was fined $50,000 by the California Department of Public Health. The Department served Saint Francis with the final decision on December 16, 2015, which stated that it "shall be effective immediately." Two weeks later, Saint Francis submitted a "Request for Reconsideration" to the Department. That was a mistake. Reconsideration was not available because the Department's decision was effective immediately. To challenge the final decision, Saint Francis needed to file a petition for writ of administrative mandate in the superior court within 30 days of service of the final decision—i.e., by January 15, 2016. (See Gov. Code, §§ 11521, 11523.) But Saint Francis did not realize that and did not promptly seek writ relief. The Department likewise did not initially realize the timeliness issue. It answered Saint Francis's reconsideration request on the merits on January 8, 2016. But the Department soon caught on. On January 14, the Department denied reconsideration on the basis that it was unavailable. Saint Francis eventually filed a writ petition on January 26, 2016—11 days too late.

The Department demurred to the writ petition on the ground it was untimely. The trial court sustained the demurrer and entered judgment for the Department. Saint Francis appealed, contending that the petition was timely, the filing deadline was equitably tolled, and the Department was equitably estopped from claiming the petition was filed late. The Court of Appeal affirmed the judgment, holding that Saint Francis' petition was untimely and neither equitable tolling nor estoppel were available remedies. The California Supreme Court granted review and reversed, holding that the first two elements of equitable tolling were satisfied and remanded the case to the Court of Appeal to determine whether the third element—"reasonable and good faith conduct on the part of the plaintiff"—was satisfied. (See July 9, 2020 CSHA Litigation Update Bulletin.)

On remand, the Court of Appeal again affirmed the judgment of dismissal, holding that it was not objectively reasonable for Saint Francis to miss the filing deadline due to its misinterpretation of the governing statutes. Although it is normally reasonable not to file a writ petition until after a reconsideration motion is resolved, reconsideration was never an available remedy here. Moreover, the fact that the Department's counsel apparently shared the mistaken belief that reconsideration was available, and that Saint Francis's petition was timely did not show that the mistake was reasonable, since determining the correct deadline "was a relatively simple matter" and "the fact that *two* attorneys failed to pay close attention does not seem to us to make the mistake any more reasonable."

Privacy rights mostly foreclose litigation discovery of non-party health care professionals' administrative records and other non-public records maintained by State agencies

Board of Registered Nursing v. Superior Court (Jan. 15, 2021, D077441) __ Cal. App.5th __ [2021 WL 140893]

The State of California sued various pharmaceutical companies, alleging that their false and misleading marketing scheme was designed to minimize the risks of opioid medications, which have caused a public health crisis by dramatically increasing opioid use, abuse, and deaths. The State alleged violations of the False Advertising Law (Bus. & Prof. Code, § 17500 et seq.), the Unfair Competition Law (id., § 17200 et seq.), and the public nuisance statutes (Civ. Code, §§ 3479–3480), and sought declaratory and injunctive relief, as well as civil penalties. During the case, the defendants served business record subpoenas on four nonparty agencies: the Nursing Board, the Pharmacy Board, the Medical Board, and the California DOJ. Defendants demanded documents in sweepingly broad categories related to opioid medications, prescriptions, overdoses, and disciplinary proceedings. Defendants aimed to rebut the State's theory that their marketing practices caused the opioid crisis by pointing the finger, instead, at misbehaving healthcare professionals and state agencies that failed to monitor or discipline health care professionals who abused or overprescribed opioids.

The trial court the ordered the agencies to produce documents in response to defendants' subpoenas, including (1) administrative records of disciplinary proceedings against providers related to opioid prescriptions; (2) investigatory files of complaints against providers related to opioid prescriptions; (3) coroner reports of opioid-related deaths that may have involved physician negligence or incompetence (Bus. & Prof. Code, § 802.5); and (4) hundreds of millions of prescription records for opioids, anti-depressants, and certain other drugs in California, as reflected in the Controlled Substance Utilization Review and Evaluation System (CURES) database maintained by the DOJ (Health & Saf. Code, § 11165). The trial court allowed the redaction of some personal identifying information contained in these documents and records. The agencies sought writ relief.

The Court of Appeal granted writ relief, holding that the trial court abused its discretion in at least four respects: (1) the defendants were required to serve consumer notices on (at least) the doctors, nurses, pharmacists, and other health care professionals whose identities would be disclosed in the administrative records, investigatory files, and coroner reports; (2) the requests for complete administrative records and investigatory files, as well as millions of CURES records, were overbroad; (3) the requests for complete administrative records and investigatory files ran afoul of the constitutional right to privacy and the statutory official information and deliberative process privileges; and (4) the defendants' motion to compel discovery from the Pharmacy Board and the Medical Board was untimely. The court rejected the defendants' argument that the Information Practices Act of 1977 (IPA; Civ. Code, § 1798 et seq.) allowed agencies to comply with the subpoenas without consumer notice, explaining that "the IPA and the consumer notice provisions work together to maximize the privacy protection afforded to persons whose personal information is implicated" and there is "no conflict between the statutory schemes that would require one statute to supersede the other." The court further explained that information in agency investigatory files, administrative records, and CURES data were protected by the official information privilege, the deliberative process privilege, and the right to privacy. The court emphasized the importance of the right to privacy "for those professionals who were investigated but

never accused of wrongdoing"; disclosing their personal information "would constitute a serious invasion of the privacy rights of these health care professionals." Finally, the court rejected the State's claim that robust statutory confidentiality provisions prohibited discovery of all information in the CURES database, but held that the defendants had failed to justify the disclosure of those records in light of the information the State had already produced.

Physician may face a negligent misrepresentation claim for steering a patient away from a procedure by falsely stating it won't be covered by insurance

Borman v. Brown (Jan. 15, 2021, D076239, D076748) __ Cal.App.5th __ [2021 WL 140844]

Alice Borman sought treatment for a droopy eyelid and eyebrow from Dr. Tara Brown. Dr. Brown allegedly told Borman that her condition could be treated with either a "brow lift" that *would not* be covered by her insurance or a blepharoplasty (removal of excess eyelid skin) that *would* be covered by her insurance. Borman had a blepharoplasty, but continued to have physical difficulties. Borman consulted another doctor, who told her that Dr. Brown had performed the wrong treatment and that a brow lift should have been performed instead. And the brow lift procedure *was* allegedly covered by insurance. Borman sued Dr. Brown for professional negligence, lack of informed consent, fraud and deceit, and battery, alleging that she falsely represented that a brow lift would not be covered by insurance, thereby steering her away from that procedure. The trial court granted defendants' motion for summary adjudication of the fraud and deceit cause of action, reasoning that Borman would be unable to establish reliance, and the jury returned a defense verdict on the remaining claims. Borman appealed.

The Court of Appeal reversed the summary adjudication. The court began by clarifying the nature of Borman's claim. The court distinguished fraud (requiring intent to *deceive*) from negligent misrepresentation (requiring only intent to *induce reliance*). The court held that Borman's complaint had adequately alleged negligent misrepresentation, but Dr. Brown's motion had addressed only fraud, not negligent misrepresentation. The court rejected Dr. Brown's argument that Borman could not prove an intent to induce reliance because Dr. Brown had no financial incentive to perform a blepharoplasty rather than a brow lift. The court reasoned that Borman could show intent to induce reliance regardless of any financial motive. Indeed, a reasonable jury could find Dr. Borman intended Borman to rely on the insurance coverage statement based on the physician consultation context in which the misrepresentation was made. In addition, Borman presented evidence that she informed Dr. Brown that she could undergo a procedure only if it was covered by insurance, which was sufficient to create a triable issue that Dr. Brown intended to induce Borman's reliance on her insurance coverage misrepresentation. Accordingly, the Court of Appeal reversed and remanded for further proceedings regarding Borman's negligent misrepresentation claim.

Physician is not liable for treatment recommendation unless no reasonable physician would recommend it

Flores v. Liu (Jan. 28, 2021, B301731) __ Cal.App.5th __ [2021 WL 282302]

Jenny Flores, who suffered from morbid obesity, consulted Dr. Carson Liu, a bariatric surgeon, regarding possible surgical weight loss treatments. Dr. Liu informed her of three gastric surgery options: a lap band, a sleeve, and a bypass. Flores initially had the lap band surgery, but she did not lose weight because she failed to maintain the required diet. She then had gastric sleeve surgery, but it was unsuccessful for the same reason. Dr. Liu then performed gastric re-sleeve surgery to further restrict the size of Flores's stomach. Dr. Liu had explained the risks and potential benefits in advance of each surgery, both orally and in writing. However, he mistakenly told Flores that both the initial gastric sleeve and the subsequent gastric re-sleeve procedures had the same 5 percent risk of complications. In reality, only the re-sleeve surgery had that level of risk; the risk associated with the initial gastric sleeve procedure was much lower. Although Dr. Liu competently performed the gastric re-sleeving, an internal leak caused complications that required Flores to be hospitalized for several weeks. Flores sued Dr. Liu for negligently recommending the gastric re-sleeving surgery, and for not obtaining her informed consent for that surgery. After the trial court instructed the jury that adequate informed consent extinguished any negligent recommendation liability, the jury returned a defense verdict. Flores appealed.

The Court of Appeal affirmed. First, the court held that the trial court erred in instructing the jury that a physician cannot be liable for making a negligent recommendation if adequate informed consent is obtained. However, that error was not prejudicial here because the negligent recommendation claim should never have gone to the jury. The court explained that a physician may be liable for negligent treatment recommendation if either: (1) the recommendation is based on a misdiagnosis of the patient's condition, or (2) *no* reasonable physician in the relevant medical community would have recommended the treatment. Thus, evidence of what treatment most doctors would recommend is insufficient, as a matter of law, to establish negligent recommendation. Here, there was no evidence of a misdiagnosis, nor was there evidence that no reasonable physician would have recommended the re-sleeving. Indeed, it was undisputed that re-sleeving is a medically appropriate treatment for morbid obesity. Moreover, the likelihood of success depended upon Flores' willingness to control her diet, and Dr. Liu was not required to assume that Flores would fail to control her diet in the future because she had failed to do so in the past.

The court further held that Dr. Liu's failure to perform an additional pre-recommendation evaluation was insufficient, as a matter of law, to establish liability because there was no evidence that a further evaluation would have changed the recommendation. Finally, the court held that substantial evidence supported the jury's finding that Dr. Liu had obtained Flores' informed consent for the gastric re-sleeving procedure since he correctly informed her of the risk associated with that procedure, and his prior overestimation regarding the risk of the earlier gastric sleeve procedure did not undermine the accurate disclosure of the risk for the surgery that was at issue.

Unlicensed companies may manage licensed skilled nursing facilities via an approved management agreement

California Advocates for Nursing Home Reform v. Arágon (Jan. 29, 2021, A158035) __ Cal.App.5th __ [2021 WL 321251]

California law requires the operator of a skilled nursing facility (SNF) to obtain a license from the California Department of Public Health (CDPH). (See Health & Saf. Code, § 1253.) A licensee may enter into an agreement with a management company to oversee the day-to-day operations. The management company does not need to hold the license, but the CDPH must approve it to manage a SNF. The requirements for SNF management approval and a SNF operator's license are similar, but the operator must meet additional financial responsibility and criminal background criteria and disclosure requirements.

In this litigation, the nonprofit group California Advocates for Nursing Home Reforms and two individuals sued the CDPH Director, two entities licensed to operate a SNF (Country Villa), and a SNF management company (CVSC), alleging that CDPH's approval of management agreements is illegal because only licensees are permitted to operate SNFs. The plaintiffs sought declaratory and injunctive relief. The trial court granted the defendants' motion for summary judgment, ruling that CDPH was authorized to approve management agreements. Plaintiffs appealed.

The Court of Appeal affirmed, holding that approving unlicensed management companies to operate SNFs does not violate any law. The court explained that Health and Safety Code section 1253 was a general prohibition against the operation of SNF without a license, which did not preclude a licensee from contracting with a management company *after* obtaining a license. Moreover, Health and Safety Code section 1267.5 anticipates the use of unlicensed management companies by requiring licensees to disclose if the SNF will be operated by a management company pursuant to a management agreement. Additionally, the statutory scheme included different requirements for a license than for the approval of an unlicensed management company. The court also rejected plaintiffs' argument that the operation of a SNF by a management company impeded the authority of the nursing home administrator and insulated the licensee from liability. While Health and Safety Code section 1416.68 defines the administrator's duty as overseeing the day-to-day management of the SNF, it also makes clear that the delegation of a SNF's management does not limit the obligations of the administrator or the licensee, which remain responsible for how the management company operates the SNF.

MICRA's noneconomic damages cap doesn't apply in calculating settlement offsets

Collins v. County of San Diego (Feb. 17, 2021, D077063) __ Cal.App.5th __ [2021 WL 612570]

Plaintiff David Collins was arrested for public intoxication. He was jailed after a nurse screened him and determined that it was medically safe to do so. He fell twice while incarcerated and was transferred to a hospital where he was diagnosed with a low sodium condition and a brain hemorrhage. Doctors at the hospital increased Collins' sodium level too quickly, resulting in serious and irreparable brain damage. He sued both the County and the hospital/physicians for his injuries. The hospital/physicians settled with Collins before trial for $2,750,000; the settlement did not apportion economic and noneconomic damages.

At trial, the jury returned a verdict awarding Collins $12,617,674 in total damages, including $8,000,000 in noneconomic damages. The jury allocated 30% fault to the deputies who arrested Collins (and interfered with the paramedics who were treating him), and 70% fault to the nurses who failed to identify his need for medical treatment. The trial court entered a judgment on the jury's verdict.

In post-trial motions, the County sought to reduce the judgment by applying the MICRA cap to Collins' noneconomic damages award against the nurses (which Collins did not oppose), and by offsetting the economic damage portion of the hospital/physicians' settlement. The trial court agreed to an offset, but not to the degree argued by the County. The trial court accepted Collins' argument that, under *Espinoza v. Machonga* (1992) 9 Cal.App.4th 268, the settlement should be allocated in proportion to the verdict—63.4% of the $2,750,000 settlement was allocated to offset noneconomic damages because 63.4% of the verdict (before any MICRA reduction) was for noneconomic damages. This allocation effectively attributed almost $2 million of the hospital/physician settlement to noneconomic damages; the trial court declined to take into account the fact that, under MICRA, the hospital/physicians could not be liable for more than $250,000 in noneconomic damages. The trial court therefore calculated a $1,006,500 economic damages offset and entered a revised judgment awarding Collins $6,261,174.

The County appealed, contending that the trial court misallocated the settlement offset. If the trial court had allocated $250,000 of the settlement to noneconomic damages (i.e., the full MICRA limit) instead of 63.4% of the verdict, the economic damages offset would have been much greater—$2,500,000—resulting in a $4,767,647 judgment, nearly $1.5 million less than the judgment entered by the trial court. But the Court of Appeal affirmed, holding that the trial court's allocation was not an abuse of discretion. The Court of Appeal construed *Rashidi v. Moser* (2014) 60 Cal.4th 718 to indicate that the MICRA cap does not apply to formulas used to account for other tortfeasors' settlement amounts.