APELLATE CASE SUMMARIES

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MICRA DOES NOT APPLY TO PARAMEDIC SUPERVISOR'S NEGLIGENT DRIVING TO ACCIDENT SCENE

Aldana v. Stillwell (Aug. 3, 2016, B259538) __ Cal.App.4th __ [2016 WL 4131373]

Paramedic supervisor Mike Stillwell drove his employer's vehicle (not an ambulance) to an accident site to supervise emergency medical technicians and provide assistance if needed. He collided with a vehicle driven by Gerardo Aldana. Aldana sued Stillwell for negligence 17 months later. The trial court granted Stillwell's motion for summary judgment based on the 1-year MICRA statute of limitations (Code Civ. Proc., § 340.5), as interpreted by *Canister v. Emergency Ambulance Service* (2008) 160 Cal.App.4th 388 (Canister) [holding that EMTs "are health care providers and negligence in operating an ambulance qualifies as professional negligence when the EMT is rendering services that are identified with human health and for which he or she is licensed"].

The Court of Appeal reversed, observing that, in *Flores v. Presbyterian Intercommunity Hospital* (2016) 63 Cal.4th 75, 88 (Flores), the Supreme Court recently clarified that "the special statute of limitations for professional negligence actions against health care providers applies only to actions alleging injury suffered as a result of negligence in rendering the professional services that hospitals and others provide by virtue of being health care professionals: that is, the provision of medical care to patients." The Aldana court questioned the continued viability of *Canister* following *Flores*. The court explained that whether Stillwell was acting within the scope of his employment was immaterial to the question whether MICRA applied. Instead, MICRA "applies only to actions alleging injury suffered as a result of negligence in . . . the provision of medical care to patients," and is therefore limited to claims arising from professional services "for which the provider is licensed." Accordingly, the trial court erred by applying the MICRA limitations period, rather than the two-year limitations period applicable to general negligence claims (Code Civ. Proc., § 335.1), because "[d]riving [a non-ambulance] to an accident victim is not the same as providing medical care to the victim" and is "outside the scope of the duties for which a paramedic is licensed."

FEDERAL LAW PREEMPTS UNFAIR COMPETITION, UNJUST ENRICHMENT AND FINANCIAL ELDER ABUSE CLAIMS BASED ON CMS-APPROVED MARKETING MATERIALS

Roberts v. United Healthcare Servs., Inc. (Aug. 4, 2016, B266393) __ Cal. App.4th __ [2016 WL 4150703]

United Healthcare offers a Medicare Advantage plan to persons who are 65 and over or disabled. (See 42 U.S.C. § 1395c.) Under a Medicare Advantage plan, an eligible beneficiary may obtain

both statutory and additional benefits. United Healthcare's written advertising materials for its plan were pre-approved by the Center for Medicare and Medicare Services. Those materials spoke of "one of the nation's largest networks, made up of local doctors, clinics and hospitals who know your community." A "Welcome Book" listed in-network providers and specified that co-payments would be $30 for in-network visits, and $50 for out-of- network visits.

Edward Roberts, a United Healthcare insured, needed urgent care and drove to a nearby out-of-network urgent care center, where he made a $50 copayment. When Roberts later discovered that United Healthcare's plan had no in-network urgent care centers in California, he filed this class action alleging unfair competition, unjust enrichment and financial elder abuse. He claimed the plan's marketing materials were misleading as to the availability (and therefore the cost) of in-network urgent care centers, and that the plan's network was inadequate. The trial court sustained United Healthcare's demurrer on the grounds that Roberts' claims were preempted by the Medicare Act and that Roberts had failed to exhaust administrative remedies.

The Court of Appeal affirmed. The court explained that the Secretary of Health and Human Services closely regulates Medicare Advantage health plans—including reviewing and promulgating regulations governing marketing materials. According to the court, those regulations expressly and impliedly preempt state laws and regulations respecting Medicare Advantage plans under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (save for carve-outs for licensing and plan solvency issues). The Court of Appeal disagreed with *Cotton v. StarCare Medical Group, Inc.* (2010) 183 Cal.App.4th 437 and *Yarick v. PacifiCare of California* (2009) 179 Cal.App.4th 1158 to the extent they construed the scope of express preemption more narrowly. The court's preemption holding disposed of Roberts' claims that United Healthcare used misleading marketing materials and provided inadequate coverage. The Court of Appeal went on to address a third claim that the trial court had believed was implicit in the complaint—a challenge to the co-pay amount for urgent care services. Finding that to be a claim for benefits, the Court of Appeal held that Roberts had failed to exhaust any administrative remedies under the applicable four-tier exhaustion scheme for Medicare beneficiaries participating in a Part C-authorized private health care plan.

KNOWLEDGEABLE PHYSICIANS MAY BE EXPERT WITNESSES EVEN IF THEY PRACTICE IN ANOTHER COUNTRY

Borrayo v. Avery (Aug. 10, 2016, A143765) ___ Cal.App.4th ___ [2016 WL _____]

Lidia Borrayo sued her orthopedic surgeon, Dr. James Avery, for medical malpractice following an unsuccessful thoracic outlet syndrome surgery. Dr. Avery moved for summary judgment based on an expert declaration stating that no malpractice had occurred. Borrayo filed an opposition supported by a declaration from Dr. Abraham Castrejon Pineda, who practices orthopedic surgery in Mexico and who examined Borrayo both before and after the surgery performed by Dr. Avery. The trial court sustained Dr. Avery's objection, ruling that Dr. Pineda's declaration was inadmissible because it failed to show "the appropriate standard of care in the United States."

The Court of Appeal reversed, holding that the trial court abused its discretion by excluding Dr. Pineda's expert declaration solely because he practiced medicine in a different country. The court explained that locality is not a controlling factor when determin-

ing the admissibility of medical expert testimony. Rather, the proper inquiry "is whether the medical expert witness has sufficient skill or experience in the field of medical practice involved in the malpractice claim, such that his testimony will assist the jury in the search for the truth." Because Dr. Pineda's declaration demonstrated that he had "sufficient knowledge of the subject to entitle his opinion to go to the jury" it was error for the trial court to exclude it.

MEDICARE ADVANTAGE ORGANIZATIONS MAY BE LIABLE UNDER FALSE CLAIMS ACT FOR SUBMITTING BIASED RISK ADJUSTMENT DATA

United States ex rel. Swoben v. United Healthcare Ins. Co., ___ F.3d ___, 2016 WL 4205941 (9th. Cir. Aug. 10, 2016)

Relator James Swoben filed a *qui tam* action against several Medicare Advantage organizations alleging that they violated the False Claims Act (FCA) by falsely certifying to the Centers for Medicare & Medicaid Services (CMS) the accuracy of "risk adjustment data," which was actually biased in order to inflate reimbursements. Specifically, Swoben alleged that the organizations performed biased retrospective medical records reviews designed to identify under-reporting diagnosis codes errors that could be corrected in order to enhance reimbursements, while deliberately avoiding the identification of over-reporting diagnosis coding errors that would have resulted in a reduction in reimbursements if corrected. The organizations allegedly employed coding companies to perform biased reviews, and used medical record review software and a flawed CMS reporting template designed to not reveal over-reporting errors. The defendants moved to dismiss. After permitting several amendments to Swoben's complaint, the district court finally denied Swoben leave to make further amendments, ruling they would be futile and cause undue delay.

The Ninth Circuit reversed, holding that the district court abused its discretion by denying Swoben leave to amend. First, the Ninth Circuit held that an amendment would not be futile because "when, as alleged here, Medicare Advantage organizations design retrospective reviews of enrollees' medical records deliberately to avoid identifying erroneously submitted diagnosis codes that might otherwise have been identified with reasonable diligence, they can no longer certify, based on best knowledge, information and belief, the accuracy, completeness and truthfulness of the data submitted to CMS. This is especially true, when, as alleged here, they were on notice that their data included a significant number of erroneously reported diagnosis codes." The Ninth Circuit acknowledged that "blind coding may help ensure the integrity of a retrospective review" because if medical record "reviewers are told in advance which codes were submitted to CMS, they may have an especially strong incentive to find support for those codes in the records under review." However, if the "Medicare Advantage organizations acquire the codes identified by retrospective coders, compare them to the codes previously submitted to CMS, identifying both under- and over-reporting errors, but withhold information about the over-reporting errors from CMS, this would result in a false certification." In addition, if the medical records selected for review fail to support the diagnosis codes submitted to the CMS, then the organizations have "been put on notice that the diagnosis may not be supported" and must investigate further to ensure that the diagnosis codes are in fact supported by other medical records, thereby ensuring the "accuracy, completeness, and truthfulness" of the submitted data. Finally, the Ninth Circuit held that, in this instance, "[u]ndue delay by itself is insufficient to justify denying leave to amend," and that defendants failed to establish how they would be prejudiced if leave to amend were granted.

SKILLED NURSING FACILITY MUST COMPLY WITH TRANSFER/ DISCHARGE REGULATIONS EVEN WHEN A TRANSFER IS ORDERED BY A HOSPICE PROVIDER

St. John of God Retirement & Care Center v. Dept. of Health Care Services Office (Aug. 17, 2016, B265488) __ Cal. App.4th __ [2016 WL 4379335]

Plaintiff Gloria Woods was a resident of St. John of God Retirement & Care Center (St. John), a skilled nursing facility. She elected hospice care through St. Liz, a provider under contract to St. John. When Woods experienced a psychotic episode, St. Liz transferred her to an acute care hospital. After her hospital treatment concluded, St. John refused to readmit Woods to the first available bed, contending that it was not required to do so under 42 Federal Code of Regulations, section 483.12 (section 483.12), because St. Liz, not St. John, had ordered her hospitalization. Following an administrative hearing, the Department of Health Care Services (DHCS) ordered St. John to readmit Woods. The superior court denied St. John's petition for writ of administrative mandate, and St. John appealed.

The Court of Appeal affirmed, holding that section 483.12 does not exempt a skilled nursing facility from the readmission requirement "solely because the transfer to an acute care hospital from which the resident is returning was ordered by the resident's hospice care provider rather than the facility itself." As a result, St. Liz's initiation of the acute hospitalization also did not exempt St. John from complying with section 483.12 provisions regarding (a) identification and documentation of a justifying circumstance, (b) the preparation and orientation for a safe and orderly transfer, and (c) notice regarding the date of the transfer or discharge and the new resident location. The court explained that "Section 483.12 expressly refers to the obligations the facility bears to a 'resident,' and does not contain any suggestion that if the resident is under the care of a hospice provider, the involuntary transfer provisions do not apply." The Court reasoned that "federal regulations would not deprive such a resident of the protections of section 483.12 simply based on whose employee – the hospice's or the facility's –determines the need for a transfer."

NO PREEMPTION OF MEDICAL PROVIDER'S CLAIMS BASED ON ERISA PLAN'S REPRESENTATIONS ABOUT PAYMENTS

Silver v. International Longshore and Warehouse Union – Pacific Maritime Association Welfare Plan (Aug. 22, 2016, B267941) __ Cal.App.4th ___ [2016 WL 4434735]

Dr. Morris Silver sued an ERISA Plan to recover payments for health care services that he provided to the Plan's policyholders. Dr. Silver's complaint alleged that, before he rendered the services, the Plan made representations to him regarding amounts it would pay for services to its policyholders. He further alleged that the Plan initially made the promised payments, but then stopped. Dr. Silver's asserted causes of action for breach of oral contract, *quantum meruit*, *promissory estoppel*, and interference with contractual relations. The trial court dismissed Dr. Silver's complaint, ruling that it was preempted by ERISA because he essentially alleged denial of coverage under an ERISA plan.

The Court of Appeal affirmed in part and reversed in part. The court explained that the case concerned conflict preemption, an affirmative defense that bars state law claims interfering with the uniform administration of ERISA plans. The court further explained that ERISA does not preempt "'run-of-the-mill state law claims such as claims for unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan,'" and case law articulates "a valid distinction between claims by a plan participant for additional benefits [which are preempted] and claims by third-party medical providers [which are not preempted]." Applying that distinction, the court held that the trial court erred when it ruled that Dr. Silver's "three contract/quasi-contract causes of action" were preempted because those claims do not seek "compensation for the Plan's decisions to deny coverage under the terms of an ERISA plan," but instead "are predicated on a garden-variety failure to make payment as promised for services rendered." However, the trial court correctly ruled that Dr. Silver's claim for interference with contractual relations was preempted because "the Plan's allegedly tortious conduct cannot be separated from the Plan's discharge of its obligations to notify participants of an adverse determination under ERISA."

EOB LETTERS REFUSING TO PAY PROVIDER'S BILLS TRIGGER THE STATUTE OF LIMITATIONS, WHICH IS NOT TOLLED BY THE PROVIDER'S PURSUIT OF ALTERNATIVE REMEDIES

Vishva Dev, M.D., Inc. v. Blue Shield of Cal. Life and Health Ins. Co. (Aug. 31, 2016, B270094) __ Cal.App.4th __ [2016 WL 4538397]

Vishva Dev, M.D., Inc. (Dev) provided emergency medical services to three patients who were insured by Blue Cross entities. Dev did not have a contract with Blue Cross, but he billed Blue Cross tens of thousands of dollars for the emergency services. Blue Cross issued Explanation of Benefits (EOB) letters stating that about 10 percent of the billed amounts would be paid, offering to consider additional information, and informing Dev of its optional internal appellate process. Dev appealed, securing a small additional payment for services to one patient. Dev then filed a *quantum meruit* action against Blue Shield. The action was filed more than two years after Blue Shield issued its EOB letters, but less than two years after the internal appeals were completed. The trial court granted summary judgment to Blue Shield on the ground that Dev's lawsuit was untimely under the two-year statute of limitations in Code of Civil Procedure section 339.

The Court of Appeal affirmed. Because Blue Shield's EOB letters unequivocally refused to pay the amount Dev billed, those letters triggered the two-year statute. The court held that the limitations period was not tolled by Blue Shield's willingness to consider additional information, or by Dev's pursuit of Blue Shield's voluntary internal appellate process.

PHYSICIAN PROPERLY CONVICTED OF A FELONY UNDER FEDERAL FDCA FOR RE-USING SINGLE-USE NEEDLE GUIDES

United States v. Kaplan, ___ F.3d ___, No. 15-10241, 2016 WL 4709870 (9th Cir. Sep. 9, 2016)

Dr. Michael Kaplan, a urologist, reused single-use needle guides on patients undergoing prostate biopsies, despite clear packaging statements that the guides were appropriate only for a single use, as well as verbal warnings from a colleague and medical staff to stop this unsafe practice. Kaplan never informed his patients that he was reusing the single-use guides. During an FDA investigation, Kaplan made inconsistent statements about how long he had been reusing the guides. He also assembled a public relations team that published a newspaper advertisement explaining his conduct; the ad claimed he reused guides for less than three weeks, even though the practice actually took place over three months. Kaplan was charged with conspiracy to commit adulteration under 18 U.S.C. § 371 in violation of the Federal Food Drug and Cosmetic Act, 21 U.S.C. §§ 331(k), 333(a)(2), and 351(a)(2)(A). A device, like a needle guide, is adulterated if "held under insanitary conditions whereby it may have been contaminated with filth, or . . . rendered injurious to health." Here, the government was required to prove that Kaplan's guides were "held for sale . . . after shipment in interstate commerce." A jury found that Kaplan was guilty and that he acted with intent to defraud or mislead, making the conviction a felony.

The Ninth Circuit affirmed. Deciding an issue of first impression, the court held that Kaplan's reuse of the single-use needle guides was considered a "sale" under § 331(k) because the guides were "consumed" in the course of treating patients. The court rejected Kaplan's arguments regarding the "practice of medicine exemption" and that his conduct was protected off-label use of the needle guides, holding that neither defense applied to the use of adulterated products. The court found there was sufficient evidence to support the conviction because "Kaplan was repeatedly made aware of the problems with reusing the guides, knew that the guides should not be reused, and persisted in reusing the guides anyway for several weeks thereafter." Finally, the Ninth Circuit determined there was sufficient evidence Kaplan intended to defraud or mislead, and thus committed a felony, by not disclosing his reuse to his patients, and by misrepresenting his conduct to the FDA and the public.

ALLEGATIONS OF HOSPITAL'S EXCESSIVE CHARGES TO UNINSURED EMERGENCY PATIENTS PLEAD COLORABLE UCL AND CLRA CLAIMS

Moran v. Prime Healthcare Management, Inc. (Oct. 5, 2016, G051391) ___ Cal.App.5th ___ [2016 WL 5815785]

Gene Moran, an uninsured patient, filed a class action against related Prime Healthcare hospital entities alleging that their "grossly excessive" charges and price discrimination against self-pay patients violated California's Unfair Competition Law (UCL) and Consumer Legal Remedies Act (CLRA). Moran had visited an emergency room three times and was billed over $10,000. During each visit, Moran signed contracts stating he was responsible for all reasonable charges listed in the hospital description master, but might be eligible for a charity or discounted payment program. The trial court sustained Prime Healthcare's demurrer without leave to amend and dismissed Moran's complaint.

The Court of Appeal affirmed in part and reversed in part. The court held that, while most of Moran's claims lacked merit, he had adequately alleged facts supporting his claim that the hospital's bills were unconscionable. The fees were procedurally unconscionable because the hospital's pre-printed contracts had to be signed by self-pay patients before they could receive even emergency treatment. The fees were substantively unconscionable because the alleged purpose of the excessive rates was to increase the profit margin on the treatment of vulnerable self-pay patients requiring emergency care. The court agreed that the Hospital Fair Pricing Act allows hospitals to charge variable pricing, but held that unconscionably high prices would violate both the UCL and CLRA. The court rejected the hospital's argument that its fees were fair because Moran could apply for a price reduction or elimination, since the application process constituted a tangible burden in the court's view. Finally, the court held that plaintiff's price discrimination claim was barred by a safe harbor provision in Business and Professions Code section 17042, and his fraud and misrepresentation claims lacked merit because he failed to allege reasonable reliance on alleged misrepresentations.

CLASS ACTION CERTIFIED AGAINST PROVIDER FOR ALLEGEDLY VIOLATING STATUTE GOVERNING CHARGES FOR MEDICAL RECORDS REQUESTED PRIOR TO LITIGATION

Nicodemus v. Saint Francis Memorial Hospital (opinion filed Sept. 14, 2016; certified for publication Oct. 6, 2016, A141500) ___ Cal.App.5th ___ [2016 WL 4800893]

Kristen Nicodemus filed a proposed class action against HealthPort Technologies and Saint Francis Memorial Hospital alleging causes of action for violations of Evidence Code section 1158 and the Unfair Competition Law. Section 1158 authorizes counsel for patients, prior to litigation, to demand that their medical providers produce their medical records for inspection and copying in a timely fashion and at specified, reasonable costs (such as 10¢ per page for reproducing documents up to 8.5 by 14 inches). Saint Francis contracted with HealthPort to review and respond to patient records requests. When Nicodemus' attorney made a section 1158 request after she was injured in an accident, HealthPort responded that the request was not subject to the statute and charged multiple handling fees and 25¢ per page. Nicodemus then filed this proposed class action seeking to represent others whose attorneys had requested patient medical records from a medical provider in California prior to litigation and were charged more than the amounts specified in section 1158. The trial court denied Nicodemus' motion for class certification on the ground she had not demonstrated the proposed class was ascertainable or that common issues predominated.

The Court of Appeal reversed and directed the superior court to certify a class. Noting that the primary purpose of the ascertainability requirement is to ensure that potential class members can be notified, the court held that ascertainability was satisfied because HealthPort's document request dataset contained sufficient information to identify attorney requesters. The court was not persuaded that class certification should be defeated simply because the class might ultimately include persons who did not qualify under section 1158. As for predominance, the court held that Nicodemus had shown the existence of a common question—whether HealthPort's uniform practice of responding to attorney requests for medical records violated section 1158. The court concluded that individualized inquiries would

not predominate: "[t]he fact that each class member ultimately may be required to establish his or her records request was submitted before or in contemplation of litigation does not overwhelm the common question regarding those uniform copying practices." Finally, the court rejected Saint Francis' arguments that it was not a proper defendant simply because some class members may have a claim against HealthPort but not Saint Francis, and that Saint Francis risked being held responsible for other non-defendant medical providers' statutory violations at the damages stage.

MICRA LIMITATIONS PERIOD APPLIES TO NEGLIGENCE DURING PATIENT TRANSFER USING A GURNEY

Nava v. Saddleback Memorial Medical Center (opinion filed Sept. 23, 2016; certified for publication Oct. 18, 2016, G052218) ___ Cal.App.5th ¬___ [2016 WL 5338541]

A patient who was injured when he fell from a gurney sued the hospital and an ambulance service for negligence nearly two years after the incident. The trial court granted both defendants' motions for summary judgment under Code of Civil Procedure section 340.5, which imposes a one-year statute of limitations on lawsuits claiming "professional negligence" by a health care provider. Section 340.5 defines professional negligence as "a negligent act or omission to act by a health care provider in the rendering of professional services." Plaintiff, who had advocated a longer statute of limitations applicable to premises liability claims, appealed.

The Court of Appeal affirmed. The court applied the rule recently announced by the California Supreme Court in *Flores v. Presbyterian Intercommunity Hospital* (2016) 63 Cal.4th 75, 88-89—the applicable statute of limitations is determined by whether the alleged negligence is integrally or only incidentally related to the medical care being provided. The court held that plaintiff's transfer on a gurney was "integrally related to his medical diagnosis or treatment" because (as plaintiff conceded) it was "subject to a medical professional's directive." Therefore, because "the negligence occurred in the rendering of professional services" the one-year statute of limitations period under section 340.5 applied.

AGENCY PRESENTING "APPALLINGLY INADEQUATE" EVIDENCE IN PETITIONING FOR RELIEF UNDER HEALTH CARE DECISIONS LAW MUST BE ASSESSED ATTORNEY FEES

Humboldt County Adult Protective Services v. Super. Ct. (A145981, Oct. 24, 2016), ___ Cal.App.5th ___ , 2016 WL 6208628

Humboldt County Adult Protective Services filed an *ex parte* petition without notice under the Health Care Decisions Law. (Prob. Code, §§ 4600 et seq.) Humboldt sought both to revoke a dying patient's valid advance care directive that appointed his wife as agent for health care decisions, and to compel medical treatment for the patient's serious heart infection. The patient had expressed his desire to receive palliative care only, as recommended by his treating physician and two other doctors, but Humboldt's petition omitted those recommendations and contained other deficiencies. Unaware of the treating physician's recommendation, the trial court granted Humboldt a temporary treatment order. After the wife was served with the order, she retained counsel who alerted the trial court to the omissions in Humboldt's petition and moved to dismiss it. Humboldt then withdrew its petition and the trial court vacated the order. The trial court then denied the wife's request for a statutory attorney fee award, and she appealed from that adverse order.

The Court of Appeal reversed, holding that no reasonable trial court would refuse to award attorney fees because, as a matter of law, Humboldt had no reasonable cause to petition for relief under the Health Care Decisions Law. The court explained that reasonable cause is measured objectively, and must be substantiated by competent evidence. Here, Humboldt failed to present sufficient evidence that it acted with reasonable cause. Indeed, the court found that Humboldt's evidentiary showing was "appallingly inadequate," "misleading," and "fraudulent" because it had (1) concealed critical evidence that palliative care had been recommended by the patient's treating physician and other doctors based on their medical assessment and the patient's wishes, (2) presented an incomplete discussion of the relevant law, and (3) tried to admit exhibits based on multiple levels of hearsay that lacked proper foundation. Under these circumstances, the trial court's only proper exercise of discretion would be to award fees to the wife.