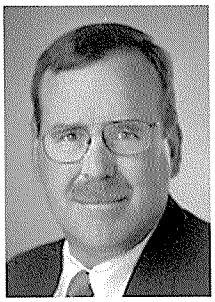
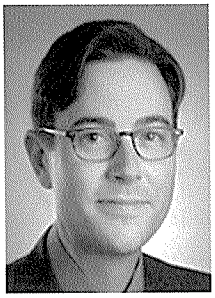
Appellate Case Summaries



By **H. Thomas Watson**
Horvitz & Levy, LLP



and **Peder K. Batalden**
Horvitz & Levy, LLP

FEDERAL MENTAL HEALTH PARITY ACT REQUIRES ERISA PLANS TO PROVIDE COMPARABLE RESIDENTIAL BENEFITS TO PATIENTS SEEKING MENTAL HEALTH AND MEDICAL TREATMENT

Danny P. v. Catholic Health Initiatives, *___ F.3d ___, 2018 WL 2709733 (9th Cir. June 6, 2018)*

A self-funded group health benefit plan covering Catholic Health Initiatives' employees and their dependents (the Plan) denied room and board coverage for plaintiff Nicole B., who was admitted to a residential treatment program for mental health issues. After exhausting the Plan's administrative remedies, Plaintiffs brought an action under ERISA for wrongful denial of benefits. The district court granted summary judgment for the Plan, ruling that the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Mental Health Parity Act) did not prohibit the Plan from providing coverage for mental health stays at licensed treatment facilities that was more restrictive than coverage for stays at skilled nursing facilities. Plaintiffs appealed.

The Ninth Circuit reversed, holding that the Mental Health Parity Act precluded the Plan from differentiating room-and-board reimbursements for skilled nursing facility stays from mental health treatment facility stays. The Ninth Circuit found the general language of the statute to be "quite clear" in directing that benefits and treatment limitations for mental health problems shall be "no more restrictive" than those for medical and surgical problems. The Ninth Circuit found no contradiction between its reading of the Act and the Interim Final Rules, which indicated that mental and medical/surgical benefits must be congruent, and that limiting the former while not placing a similar limitation on the latter would be improper.

HOSPITAL CAN'T SEEK RECONSIDERATION OF DEPT. OF HEALTH DECISION "EFFECTIVE IMMEDIATELY" AND MUST SEEK WRIT RELIEF WITHIN 30 DAYS

Saint Francis Memorial Hospital v. California Department of Public Health *(May 23, 2018, A150545) ___ Cal.App.5th ___ [2018 WL 3007483], ordered published June 15, 2018*

The California Department of Health fined St. Francis Hospital $50,000 for lacking appropriate sponge-count policies after a sponge was left in a patient during surgery. At a subsequent hearing, an administrative law judge found there was no basis for the fine because St. Francis had adequate policies. The Department rejected the ALJ's findings and issued a final decision affirming the fine "effective immediately." St. Francis sought reconsideration, which the Department denied without notifying St. Francis that its request was void. St. Francis then filed a petition for writ of administrative mandamus. The trial court sustained the Department's demurrer, ruling

that (1) because the Department's decision was effective immediately, St. Francis was not permitted to seek reconsideration and therefore its writ petition was untimely (not filed within the 30-day deadline in Government Code section 11523), and (2) there was no basis for equitable tolling because St. Francis's untimely filing was attributable to a mistake of law, rather than a mistake of fact.

The Court of Appeal affirmed, holding that St. Francis's request for reconsideration did not extend its deadline for seeking writ relief. Under Government Code section 11521, the time to request reconsideration expires on the effective date of the Department's decision. Because the Department made its decision "effective immediately," it eliminated St. Francis's opportunity to seek reconsideration. St. Francis had waited to file its writ petition until the Department decided its reconsideration request—41 days after the "effective immediately" decision—and thus its petition was untimely. Additionally, the court held that equitable tolling did not apply. Such tolling is available when a party with multiple available remedies pursues one in a timely manner. Here, however, St. Francis' request for reconsideration was not an available remedy since reconsideration was barred by section 11521. Moreover, the Department's failure to inform St. Francis that its request for reconsideration was void (because of section 11521) did not equitably toll or estop the Department from asserting the statutory deadline because the Department made no affirmative representations that caused St. Francis's mistaken understanding of the law and St. Francis could not reasonably rely on the Department to correct its own legal misunderstandings.

PREEMPTED STATE LAW NO BAR TO COMPELLING AGENCY TO PROCESS REIMBURSEMENT CLAIMS REQUIRED BY MEDICAID ACT

American Indian Health & Services Corporation v. Kent *(June 19, 2018, C081338) __Cal.App.5th__ [2018 WL 3031822]*

A group of federally qualified health centers (FQHCs) and rural health clinics (RHCs), filed a petition for writ of mandate seeking to compel the California Department of Health Care Services to process their claims for retroactive payment for dental, chiropractic, and podiatric services provided to Medi-Cal eligible patients. The Department had withheld payment for these services under Welfare and Institutions Code section 14131.10, which excluded coverage for these services to the extent permitted by federal law, on the basis that they were not "physicians' services" under the Medicaid Act. While the Ninth Circuit in *Cal. Ass'n of Rural Health Clinics v. Douglas* (9th Cir. 2013) 738 F.3d 1007 (CARHC) had previously ruled that section 14131.10 was invalid to the extent it eliminated coverage for these services when provided by FQHCs and RHCs, the Department refused to reimburse Plaintiffs for care provided before the date of the CARHC decision.

The trial court granted the petition in part, ruling that the Department had to process and pay for all services provided before the CARHC decision, and had to follow existing regulations governing late claims.

The Court of Appeal affirmed, explaining that a mandamus proceeding is not barred by sovereign immunity when it seeks to compel compliance with a mandatory duty, even if that duty requires the release of funds. Since the plaintiffs' petition merely sought a process that could lead to payment of qualified claims, and since the judgment itself did not award damages, sovereign immunity did not bar the action. Additionally, the court held that CARHC applied retroactively to this and other cases still pending because it did not declare new law but merely interpreted the clear and unambiguous requirement that dental, chiropractic, and podiatric services were "physicians' services" and therefore subject to reimbursement under the Medicaid Act. Accordingly, the Department should have anticipated that the Ninth Circuit would hold section 14131.10 to be invalid.

RESIDENTIAL CARE FACILITY CANNOT COMPEL ARBITRATION OF CONSORTIUM CLAIM BY SPOUSE WHO DID NOT AGREE TO ARBITRATE

Williams v. Atria Las Posas *(June 27, 2018, B282513) __Cal.App.5th__ [2018 WL 3134869]*

John Williams was admitted to Atria Las

Posas, a residential care facility, after suffering major brain and other injuries in an accident. Williams signed Atria's Residency Agreement, which included an integration clause but not an arbitration clause, and then he executed a separate arbitration agreement. Williams's wife, Vicktoriya Marina-Williams, did not sign either agreement. Shortly after his admission, Williams walked away from Atria and was later found in a ditch with a second brain injury. Both Williams and Marina-Williams sued Atria and a primary care physician for negligence and loss of consortium. Atria petitioned to compel arbitration. The trial court denied Atria's petition, concluding that the Residency Agreement integration clause was "dispositive" and prevented the court from considering the separate arbitration agreement.

The Court of Appeal reversed in part, holding that the Residency Agreement superseded only prior agreements and not the arbitration agreement later executed by Williams and which specifically provided that it covered claims arising out of the residency agreement. The court affirmed in part, holding that Marina-William could not be compelled to arbitrate because she did not sign the arbitration agreement and her loss of consortium claim was not derivative of Williams's negligence claim. Finally, the court remanded for the trial court to determine whether the conditions of Code of Civil Procedure section 1281.2, subdivision (c)—providing a third party litigation exception to arbitration—were satisfied. The court rejected Atria's argument that the Federal Arbitration Act (FAA) and not section 1281.2 controlled. The court reasoned that, because the agreement stated that the parties would arbitrate under the FAA or California law in the event a court determined that the FAA did not apply, the agreement did not preclude application of section 1281.2.

CAUSATION TESTIMONY OF NONRETAINED PHYSICIAN WHO FAILED TO REVIEW MEDICAL RECORDS LACKS FOUNDATION

Belfiore-Braman v. Rotenberg *(June 26, 2018, D072015) __ Cal.App.5th __ [2018 WL 3120174], certified for publication July 13, 2018*

Plaintiff Angela Belfiore-Braman complained of sciatic nerve injury following hip replacement surgery by Dr. Daniel Rotenberg. In Belfiore-Braman's ensuing medical malpractice litigation against Dr. Rotenberg, she sought to introduce medical opinion testimony from a nonretained expert, Dr. Aaron Filler, regarding an imaging study he conducted that allegedly indicated that the surgery may have caused her injury. The trial court excluded Dr. Filler's testimony, ruling that it lacked foundation and was unduly duplicative of Belfiore-Braman's orthopedic surgeon expert's testimony. The jury returned a defense judgment, and Belfiore-Braman appealed.

The Court of Appeal affirmed, holding that the trial court did not abuse its discretion in excluding Dr. Filler's testimony on causation and damages. First, Dr. Filler's testimony lacked an adequate foundation because he did not perform the hip replacement surgery and did not review the operative report or medical records. Additionally, the trial court properly excluded Dr. Filler's proffered testimony about possible excessive use of force as cumulative, because plaintiff's expert orthopedic surgeon had already testified that the operative report showed the nerve had been stretched too far during the surgery and that this was a substantial factor in contributing to plaintiff's sciatic nerve injury.

THE FEDERAL TORT CLAIMS ACT GOVERNS MEDICAL MALPRACTICE CLAIMS, BUT THE VETERAN'S JUDICIAL REVIEW ACT GOVERNS VA ADMINISTRATIVE NEGLIGENCE CLAIMS

Tunac v. United States *(9th Cir., July 30, 2018, No. 17-15021) __ F.3d __ [2018 WL 3614044]*

Felisa Tunac sued the United States under the Federal Tort Claims Act (FTCA) for wrongful death and medical malpractice after her husband Randy died from kidney failure while a patient at a Veterans Affairs (VA) hospital. Although Randy's blood test indicated kidney failure, the VA hospital took three months to schedule a biopsy, which confirmed end-stage kidney disease requiring dialysis. The VA hospital

scheduled Randy's dialysis appointment for nearly a month later, but he died from renal failure seven days before the appointment. Two weeks later, the VA sent a letter addressed to Randy notifying him that his kidney disease required immediate treatment or would result in "end-stage kidney disease or death." About four and a half years later, Tunac saw media reports that gross mismanagement and unacceptable wait times at the VA hospital had contributed to preventable veteran deaths. Less than one year later, Tunac filed an administrative claim with the VA, which it denied. In the ensuing district court action, the court concluded it had jurisdiction to hear some of Tunac's claims, but dismissed them as untimely.

The Ninth Circuit affirmed. First it decided the threshold jurisdiction issue, holding that the portion of Tunac's complaint alleged medical negligence by VA healthcare employees was governed by the FTCA. Accordingly, those claims need not proceed under the Veterans' Judicial Review Act (VJRA), which requires that VA benefits decision be reviewed exclusively by the Veterans Court, whose decisions are reviewable exclusively by the Federal Circuit. However, to the extent Tunac alleged negligence in scheduling appointments and treatment, the Ninth Circuit lacked jurisdiction because such allegations did not give rise to a reasonable inference that VA medical professionals breached their duty of care, but rather sought relief for administrative negligence that must be channeled through VJRA procedures. After confirming its jurisdiction, the Ninth Circuit determined that Tunac's malpractice claims accrued no later than when she received the VA's letter explaining the potentially fatal consequence of delayed treatment, and were untimely because she initiated her administrative action well after FTCA's two-year limitations period had elapsed.

ADMINISTRATIVE PROCEEDINGS AGAINST THE CMS IS THE EXCLUSIVE MEANS FOR ASSERTING A SUBSTANTIVE CHALLENGE TO REDUCED MEDICAID REIMBURSEMENT RATES

Santa Rosa Memorial Hospital, Inc. v. Kent *(July 31, 2018, A151588) __ Cal. App.5th __ [2018 WL 3629142]*

A group of hospitals filed petitions for writ of mandate against Director of the California Department of Health Care Services (DHCS), seeking to void the DHCS's implementation of state legislation that reduced the Medicaid reimbursement rate to hospitals that were not under negotiated rate contracts with the state, and an award of nearly $100 million in additional reimbursements. After the legislation was enacted, the DHCS published notices explaining the reductions and submitted state plan amendments incorporating them to the federal agency responsible for administering Medicaid, the Centers for Medicare & Medicaid Services (CMS), which approved the amendments. The hospitals' writ petitions argued that the DHCS violated sections 13(A) and 30(A) of the Medicare Act (42 U.S.C. §§1396a(a)(13)(A) & (a)(30)(A)), which set out the procedural and substantive requirements that a state must follow when establishing reimbursement rates. The trial court denied writ relief.

The Court of Appeal affirmed. First, the court held that it had no jurisdiction to consider the hospitals' challenges to the DHCS's implementation of rates approved by the CMS based on the substantive requirements of section 30(A). Rather, such challenges must be brought exclusively in administrative proceedings against the CMS, followed by judicial review of that agency's final determination under the Administrative Procedures Act. The court explained that, while a writ of mandate may compel performance of a ministerial duty, section 30(A) prescribes standards that are "so broad and nonspecific that they are 'judicially unadministrable.'" The court then held that, although the hospitals could obtain writ relief for violations of the procedural requirements of section (13)(A), no such violation occurred here. The court rejected the hospitals' contention that section 13(A) was violated because they had inadequate notice of the state legislation that approved the reduced reimbursement rates, explaining that section 13(A) permits notice of statutory rate changes after enactment of the legislation but prior to the effective date of the rate change by the DHCS, which is what occurred here.

ONLY EGREGIOUS UNDERSTAFFING SUPPORTS ELDER ABUSE LIABILITY AGAINST NURSING FACILITY

Cochrum v. Costa Victoria Healthcare, LLC *(July 12, 2018, G052934) __ Cal. App.5th __ [2018 WL 3751397], ordered published August 8, 2018*

Harvey Cohoon resided at a skilled nursing facility while he underwent cancer treatment. After he was observed having difficulty swallowing, he was placed on a restricted diet, but this change was not communicated to the kitchen. During his next meal, Cohoon aspirated on his food and ultimately passed away. His next of kin filed suit against the facility for elder abuse, negligence, and wrongful death. The jury returned a verdict for plaintiff on all three counts. The trial court granted defendants' motion for judgment notwithstanding the verdict on the elder abuse claim, concluding that there was insufficient evidence of recklessness. The trial court also concluded that MICRA's cap on noneconomic damages applied to the nursing facility, but not its parent company. Both sides appealed.

The Court of Appeal affirmed. As to the elder abuse claim, the court first noted that plaintiff failed to show the nursing facility was reckless in its care. Plaintiff pointed primarily to understaffing at the facility as proof of recklessness, but the court noted that the facility met the legally minimum staffing level, and that there was no evidence that staff shortages had contributed to patient safety issues. The Court of Appeal did caution, however, that "understaffing could amount to recklessness if it is sufficiently egregious." Turning to defendants' cross-appeal, the court noted that MICRA's cap on noneconomic damages applies only to a "health care provider." While the nursing facility itself was a health care provider, the administrator from the facility's parent company responsible for understaffing the facility was not. Thus, MICRA's noneconomic damages cap applied only to the portion of the damages award assessed against the nursing facility and not to the award as a whole, which included damages against the parent company for its direct negligence.

WORKER'S CLAIM AGAINST UTILIZATION REVIEW PHYSICIAN MUST BE RESOLVED IN THE WORKERS' COMP SYSTEM

King v. CompPartners, Inc. *(Aug. 23, 2018, S232197) __ Cal.5th __ [2018 WL 4017874]*

Plaintiff Kirk King was prescribed the psychotropic medication Klonopin by his treating physician for anxiety and depression associated with a work-related back injury. Another physician, Dr. Naresh Sharma, later conducted a workers' compensation utilization review pursuant to Labor Code section 4610, subdivision (a), determined the Klonopin was medically unnecessary, and decertified it. King and his wife then sued Dr. Sharma and CompPartners, Inc. (Dr. Sharma's employer) under various tort theories, seeking damages for seizures caused by the immediate withdrawal of the Klonopin. The trial court sustained a demurrer without leave to amend, ruling that the Kings' claims were preempted by the Workers' Compensation Act (WCA) because they arose out of a utilization review decision. The Court of Appeal affirmed the order sustaining the demurrer but reversed the denial of leave to amend, finding that the exclusivity provisions of the WCA did not apply to the extent King complained of Dr. Sharma's failure to warn King of the adverse consequences of abruptly stopping Klonopin.

The Supreme Court granted review, holding that the trial court's order sustaining the demurrer should be affirmed in full. The Court explained that California's workers' compensation system provides the exclusive remedy not only for workplace injuries but also for injuries "collateral to or derivative of" workplace injuries. Because the Kings' alleged injuries derived from a compensable workplace injury, their claims fell within the scope of the workers' compensation bargain. Even though the Kings sought damages against a third-party utilization review organization and its employees—instead of the claimant's employer—the Court held the WCA exclusive remedy rule applied because utilization reviewers are alter egos of employers for purposes of preemption. The statutory provisions governing utilization review, viewed in the broader context of the WCA, evince

the Legislature's intent that the workers' compensation system encompass all disputes concerning utilization review, whether they result from actions taken by the employer, the employer's insurer, or by a third-party utilization review organization hired to handle the review for an employer. Finally, the Court acknowledged that the exclusive remedy rule does not bar a tort claim based on conduct that was "so extreme and outrageous that 'the defendant 'in effect stepped outside of its role' as contemplated by the worker's compensation scheme." However, that exception did not apply here, even though the Kings had pleaded a claim for intentional infliction of emotional distress against Dr. Sharma.

QAWI ORDER—COMPELLING INVOLUNTARY MEDICATION OF MENTALLY DISORDERED OFFENDER—DID NOT VIOLATE CONSTITUTIONAL RIGHTS

California Department of State Hospitals v. A.H. *(Sept. 21, 2018, B286187) __ Cal. App.5th ____ [2018 WL 4519929]*

Mental health professionals at a state hospital prescribed antipsychotic medication to A.H., a mentally disordered offender whose mental disorders regularly resulted in violent outbursts against himself and others. A.H. objected to the medication, claiming that his religion—in which he was the sole prophet and worshiper of the deity Zahara—prohibited him from taking any synthetically manufactured medication. The hospital conducted two administrative proceedings, which confirmed that the antipsychotic medication was required. A.H. unsuccessfully petitioned the superior court for writ relief. The trial court ruled that, under *In re Qawi* (2004) 32 Cal.4th 1, the hospital was authorized to involuntarily administer medication to treat a dangerous or incompetent mentally disordered offender, and substantial evidence supported the hospital's administrative decision to medicate A.H. A.H. appealed, contending the *Qawi* order was not supported by substantial evidence and that it violated his First Amendment Free Exercise and Due Process rights.

The Court of Appeal affirmed. First, A.H's long history of violence and psychotic episodes were substantial evidence supporting the trial court's *Qawi* order. Second, A.H.'s Free Exercise claim was not supported by credible evidence that his religious beliefs were genuine. He personally and recently wrote the religious teachings specifically to support his claim, and his newly found religious insight was inconsistent with his voluntary practice to take another synthetic antipsychotic medication. Further, the state had a compelling interest in caring for the mentally incompetent offender and preventing him from hurting himself or others. Finally, A.H.'s Due Process claim failed because the hospital followed the established statutory, administrative, and case law authority in obtaining the *Qawi* order.

PROVIDERS SEEKING STATE-LAW WRIT RELIEF IN FEDERAL COURT TO COMPEL COMPLIANCE WITH MEDICAID ACT MAY SEEK ATTORNEY FEES UNDER STATE LAW

Indep. Living Ctr. of So. Cal., Inc. v. Kent, *__ F.3d __, 2018 WL 6072624 (9th Cir. Nov. 21, 2018)*

In 2008, California enacted legislation that reduced the Medi-Cal reimbursement rate for healthcare providers by 10 percent. A group of healthcare industry advocates and providers filed a petition for a writ of mandamus in state court against the Director of the California Department of Health Care Services, alleging that the reduction violated the federal Medicaid Act. The Director removed the case to federal court because it presented a federal question. Ultimately, the case settled favorably for plaintiffs, who moved for attorneys' fees under California's Private Attorney General statute—Code of Civil Procedure section 1021.5. The district court denied the motion, ruling that state law on attorney's fees should not apply to an action involving federal claims.

The Ninth Circuit reversed, explaining that the plaintiffs did not assert a federal claim because the Medicaid Act did not authorize a private right of action. Instead, their claim arose under state law—specifically, California Code of Civil Procedure section 1085, which permits "any court" to issue a writ compelling state agencies to perform acts prescribed by law. The Court noted

the peculiarity that the defendants had removed a state-law claim under federal question jurisdiction. The state-law character of the plaintiffs' claim did not become federal merely because they sought to compel the defendants' compliance with federal law and a federal court exercised jurisdiction. Concluding that applying state law was also consistent with the Erie doctrine, the Ninth Circuit held that the district court should have applied the state-law statute to determine whether plaintiffs were entitled to an attorneys' fees award.

NURSING LICENSE APPLICANT'S SHOPLIFTING CONDUCT ENTITLED NURSING BOARD TO RESTRICT LICENSE EVEN THOUGH HER SHOPLIFTING CONVICTIONS COULD NOT BE CONSIDERED

Moustafa v. Bd. of Registered Nursing *(Dec. 10, 2018, No. A150266) ___ Cal. App.5th ___ [2018 WL 6444019]*

Radwa Mohamed Moustafa applied to become a registered nurse. She disclosed on her application to the California Board of Registered Nursing that she had four misdemeanor convictions previously dismissed under Penal Code section 1203.4 upon completion of probation. The Board granted her only a probationary license. Moustafa petitioned the trial court for a writ of administrative mandate to remove that restriction on her license. The trial court granted the petition, ruling that the probationary license violated Business and Professions Code section 480(c)'s prohibition against denying or restricting a license based on convictions dismissed under Penal Code section 1203.4.

The Court of Appeal reversed, holding that even if section 480(c) prohibited restricting a license based on a dismissed conviction, the Board could still restrict a license based on the conduct underlying the conviction. (The court noted a recent amendment to section 480(c) that prohibits the Board from relying on underlying conduct as well, but explained that the amendment won't take effect until 2020.) The court explained that probationary licenses are appropriate where the applicant's conduct was "unprofessional" and "substantially related to the practice of nursing." Because Moustafa's recent convictions involved shoplifting, the court held the standard was satisfied: "nurses hold positions of extreme trust and have access to the property of others."

PROSECUTOR PETITIONING FOR CIVIL COMMITMENT OF A SEXUALLY VIOLENT PREDATOR MAY OBTAIN MENTAL HEALTH TREATMENT RECORDS AND SHARE THEM WITH A RETAINED EXPERT

People v. Superior Court (Smith) *(Dec. 13, 2018, No. S225562) ___ Cal.5th___ [2018 WL 6564828]*

Under the Sexually Violent Predators Act, an individual designated as a sexually violent predator (SVP) may be subject to civil commitment. The designation is determined in a trial, where the government relies upon evaluations from mental health professionals chosen by the State Department of State Hospitals.

In this case, after protracted litigation delays, the district attorney who had originally petitioned to commit Smith as a SVP more than a decade earlier requested an updated mental health evaluation and sought an order permitting the DA's retained expert to review the Department evaluation and related documents. The trial court denied the request. The Court of Appeal granted the DA's petition for writ relief, explaining that the DA already had "lawful possession" of the documents under the Act and the government's interest in protecting the public from SVPs outweighed Smith's privacy interest in the documents.

The Supreme Court granted review and affirmed. The Legislature had amended the Act two years earlier to clarify that evaluation records "shall be provided to the attorney" filing a SVP petition. The Court rejected Smith's contention that the amendment could not retroactively apply to permit the DA to review his earlier evaluations, explaining that the earlier documents were used in connection with Smith's updated or replacement evaluations and therefore fell within the scope of documents the statute permitted the DA to review. The Court further held that the Act permits the DA to share the confidential mental health evaluation records with his

retained expert. According to the Court, the Act allows attorneys for both sides to "use the records in proceedings"under the Act, which necessarily encompasses expert witness evaluation of the confidential mental health documents.

HEALTH CARE EMPLOYEES WHO WORK MORE THAN 12 HOURS PER DAY MAY WAIVE THEIR SECOND MEAL BREAK

Gerard v. Orange Coast Memorial Medical Center *(Dec. 10, 2018, No. S241655) ___ P.3d ___ [2018 WL 6442036]*

Labor Code section 512 requires employers to provide a second meal period to employees working more than ten hours. Section 512 also prohibits employees working more than twelve hours from waiving this second meal period. Soon after section 512 was enacted, the Industrial Welfare Commission (IWC) issued Wage Order 5, which allows health care workers working more than twelve hours to waive their second meal period. After the IWC adopted Wage Order 5, the Legislature enacted a law mandating that all new Wage Orders comply with section 512.

In this case, health care workers who often worked more than twelve hours per day sued their employer for permitting them to waive their second meal period, claiming that it violated section 512 and that they were entitled to unpaid wages. While the litigation was pending, the Legislature again amended the Labor Code to authorize Wage Order 5. The Court of Appeal then held that the employer's policy of allowing a second meal period waiver was permissible.

The Supreme Court granted review and affirmed, holding that Wage Order 5 permits health care workers working more than twelve hours per day to waive their second meal period. The Legislature's most recent amendment was not retroactive, meaning that it applied only to new Wage Orders adopted after Wage Order 5. Because the Legislature had previously granted the IWC authority to issue any order consistent with worker health and welfare—"notwithstanding any other provision of law"—Wage Order 5 (allowing second meal period waiver) remained in effect.

PLAINTIFFS SEEKING NOMINAL STATUTORY DAMAGES UNDER THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT MAY DEMAND A JURY TRIAL

Brown v. Mortensen *(Jan. 3, 2019, No. B281704) ___ Cal.App.5th ___ [2019 WL 92023]*

Patient Robert Brown owed a debt to his dentist. The dentist referred the debt to a collection agency owned by Stewart Mortenson, which allegedly transmitted confidential medical information to several consumer credit reporting agencies. Brown sued Mortenson for violating the Confidentiality of Medical Information Act (CMIA) (Civ. Code, §§ 56 et seq.). The trial court denied Brown's request for a jury trial on his CMIA claims for nominal statutory damages and attorney fees.

The Court of Appeal reversed in part, holding that the state Constitution affords a right to a jury trial in actions seeking nominal statutory damages under the CMIA. The court noted that a jury trial right exists for actions arising"at law" and that penalties—the essential function of CMIA statutory damages—were historically recovered through legal, rather than equitable, actions. The court affirmed as to attorney fees because there is no right to trial (let alone a jury trial) on fees under the CMIA. The CMIA permits attorney fees as incidental relief to a prevailing plaintiff (rather than as damages), so plaintiffs must seek them by posttrial motion.

EXPERT'S CONCLUSORY DECLARATION REGARDING MEDICAL CAUSATION IS INSUFFICIENT TO PREVENT SUMMARY JUDGMENT

Fernandez v. Alexander *(Jan. 28, 2019, No. B283949) __Cal.App.5th___ [2019 WL 336517]*

Plaintiff Victoria Fernandez sought medical treatment for a fractured wrist from Dr. Charles Alexander, an orthopedic surgeon who recommended placing the wrist in a cast. Fernandez later sued Dr.

Alexander for professional negligence, alleging that her wrist was in worse condition after the cast was removed, and that Dr. Alexander negligently failed to recommend and perform surgery on her wrist. Dr. Alexander moved for summary judgment, relying on the declaration of a medical expert who opined that nothing Dr. Alexander did or failed to do caused any harm because either course of treatment (a cast or surgery) might require more surgery. Fernandez opposed the motion, relying on the declaration of a medical expert who opined that Dr. Alexander breached the standard of care by not recommending surgery, which caused further deformation of Fernandez's fractured wrist. The trial court granted summary judgment, ruling that Fernandez's expert opinion evidence was too conclusory and speculative to create a triable issue regarding medical causation. Fernandez appealed.

The Court of Appeal affirmed. First, the court held that Dr. Alexander satisfied his burden of making a prima facie showing that Fernandez could not establish causation. The court then held that Fernandez failed to produce a competent expert declaration to the contrary. The court explained that Fernandez's expert declaration regarding causation was a barebones statement: it did not explain how Dr. Alexander's specific actions resulted in the injury or how an initial surgery would have produced a better outcome. Accordingly, the trial court properly granted summary judgment.

HOSPITAL LIABLE FOR DAMAGES FOR INDUCING PHYSICIAN'S MEDICAL GROUP NOT TO SCHEDULE HIM FOR WORK WITHOUT AFFORDING PEER REVIEW RIGHTS

Economy v. Sutter East Bay Hospitals
(Feb. 4, 2019, A150211, A150738, A150962) __ Cal.App.5th __ [2019 WL 422346]

Dr. Kenneth Economy was employed by East Bay Anesthesiology Medical Group, which had a contract to provide all anesthesia services at Sutter East Bay Hospital. At an unannounced inspection, the California Department of Public Heath found that Dr. Economy was responsible for numerous deficiencies regarding the use of the drug Droperidol, which placed patient safety at risk and jeopardized the hospital's credentials. After completing a continuing education course mandated by the hospital's anesthesiology peer review committee, Dr. Economy was reinstated with monitoring. A pharmacy manager then found that Dr. Economy repeatedly violated the hospital's policy for administering medication. A hospital executive spoke to the medical group, which again took him off the anesthesia schedule. The medical group told Dr. Economy he could not return to the hospital and asked him to resign. When he refused to resign, the medical group terminated him.

Dr. Economy sued Sutter, contending it violated his right to notice and a peer review hearing under Business and Professions Code section 809 et seq. and his common law due process rights under Anton v. San Antonio Community Hospital (1977) 19 Cal.3d 802. Dr. Economy prevailed at a bench trial. The court found that Sutter was required to provide him with a formal notice of charges and peer review and appellate process before removing him from the anesthesia schedule. The court awarded Dr. Economy nearly $4 million in damages for lost past and future income. Sutter appealed the judgment and the Dr. Economy cross-appealed the denial of his motion for fees and costs.

The Court of Appeal affirmed the judgment for Dr. Economy, holding that Sutter violated his statutory and common law rights to notice and peer review by directing his employer to remove him from the schedule. The court rejected the hospital's argument that no peer review was required because it never formally rescinded Dr. Economy's privileges, and that the medical group rather than the hospital terminated Dr. Economy. The court explained that, if Sutter's argument were accepted, Dr. Economy's "right to practice medicine would be substantially restricted without due process and, despite the hospital's concern that plaintiff was endangering patient safety, the state licensing board would never be notified." Moreover, "the hospital's decision not to accept any [anesthesiologist] schedule on which [Dr. Economy] was included effectively prevented [Dr. Economy] from exercising clinical privileges at the hospital and engaging in the practice of medicine,"

and was therefore "the functional equivalent of a decision to suspend and later revoke [Dr. Economy's] clinical privileges."

The court affirmed the award of lost income, rejecting Sutter's argument that Dr. Economy was required to prove that he would have prevailed at a peer-review hearing had one been held. The court stated that, at most, Sutter may have had an affirmative defense to Dr. Economy's damages claim, but it failed to establish that Dr. Economy would not have prevailed at a properly noticed peer review proceeding. The court nevertheless rejected Dr. Economy's cross-appeal for fees and costs, finding that Sutter's defense was "not frivolous, unreasonable, without foundation, or in bad faith."

MEDICAL BOARD MUST DEMONSTRATE GOOD CAUSE FOR PRODUCTION OF MEDICAL RECORDS THAT OVERCOMES PATIENT PRIVACY RIGHTS

Grafilo v. Cohanshohet *(Jan. 22, 2019, B285193) __ Cal.App.5th __ [2019 WL 764036]*

The Medical Board of California received an anonymous complaint alleging that Dr. Kamyar Cohanshohet was prescribing excessive narcotics to his patients. After obtaining a report from the Controlled Substance Utilization Review and Evaluation System (CURES) identifying the amount of controlled substances Dr. Cohanshohet prescribed, a Board investigator identified five patients who were possibly prescribed excess doses. The patients refused to release their medical records. Dr. Cohanshohet asserted his patients' privacy rights and refused to comply with a subpoena to turn them over. The Board then filed a petition seeking an order compelling production of the records.

At a hearing, the Board presented the CURES report and evidence that the five patients were individually prescribed medications that exceeded normal acceptable doses, and argued that their medical records were necessary to determine if Dr. Cohanshohet had performed adequate medical examinations and obtained proper informed consent for these high-dose prescriptions. In opposition, Dr. Cohanshohet presented evidence that the standards relied upon by the Board were not in effect when prescriptions were issued and were merely guidelines inapplicable to the cancer treatment, palliative care, and end-of-life care patients that Dr. Cohanshotet treated. The trial court granted the petition and Dr. Cohanshohet appealed.

The Court of Appeal reversed, explaining that the Board must demonstrate good cause to compel the production of medical records that overcomes patients' significant privacy interests. In balancing the Board's showing against the patients' privacy interests, the court noted the Board presented no evidence that Dr. Cohanshohet failed to properly examine or diagnose his patients, or that his practice deviated from similarly situated doctors. The court concluded that, absent such evidence, the Board had failed to establish good cause.

HEALTH INSURER MAY INCLUDE OUT-OF-NETWORK PAYMENTS IN DETERMINING ITS ACA MEDICAL LOSS RATIO

Morris v. California Physicians' Service, *___ F.3d ___, No. 17-55878, 2019 WL 1233466 (9th Cir. Mar. 18, 2019)*

The Affordable Care Act requires insurers to calculate a Medical Loss Ratio (MLR), which is the ratio between its payments for medical services and its revenues. The insurer must pay a rebate to its enrollees if its payments for medical services are less than 80% of its revenues. Blue Shield had mistakenly included out-of-network physicians in its directory of in-network physicians, causing enrollees to see out-of-network physicians and pay higher rates. Blue Shield agreed to reimburse the enrollees for the higher cost of the out-of-network physicians, and it included those reimbursement payments in its annual MLR calculation. A class of enrollees sued Blue Shield for paying an insufficient rebate, arguing that Blue Shield improperly inflated its MLR by including the settlement payments. The enrollees argued the MLR should include payments to in-network providers only. The trial court dismissed this claim, reasoning the MLR could include payments to out-of-network providers.

The Ninth Circuit affirmed. Neither the text of the Affordable Care Act nor its implementing regulation distinguishes between in-network and out-of-network providers for purposes of the MLR calculation. Further, the purpose of the MLR was to incentivize insurers to make payments for medical services, an outcome that is achieved by including all payments in the MLR calculation, regardless of network coverage.

MICRA NOTICE OF INTENT TO SUE DOES NOT TOLL GOVERNMENT CLAIMS ACT DEADLINES

Last Frontier Healthcare Dist. v. Superior Court *(March 26, 2019, No. C087953) __ Cal.App.5th __ [2019 WL 1349491]*

Plaintiff Jamie Harper was allegedly injured during a surgery at the Modoc Medical Center, a public entity. Almost a year later, her counsel sent Modoc notice of intent to sue, as required by MICRA. (See Code Civ. Proc., § 364.) Modoc treated the notice as a government claim, and rejected it as untimely. (See Gov. Code, § 911.2, subd. (a) [notice of claim must be submitted within 6 months after the cause of action accrues].) Harper submitted an application for leave to file a late claim, which expressly acknowledged that her claim had accrued nearly 14 months earlier but asserted that the tardiness was excused because her counsel did not know that Modoc was a public entity. Harper then sued Modoc for medical malpractice. Modoc denied Harper's late claim application on the ground it was untimely. (Gov. Code, § 911.4, subd. (b) [late claim applications must be filed within 1 year after accrual].) Harper petitioned the superior court for writ relief. (Gov. Code, § 946.6, subd. (c) [trial court may grant relief from denial of timely late government claim application].) The court granted Harper's petition, ruling that her tardiness was due to excusable neglect and that her initial notice of intent to sue tolled the deadline for seeking leave to file a late claim under the rationale of Wood v. Young (1991) 53 Cal.3d 315 [medical malpractice statute of limitations tolled by service of notice of intent to sue]. Modoc sought writ review.

The Court of Appeal granted writ relief, holding that Harper's notice of intent to sue did not toll the jurisdictional deadlines under the Government Claims Act. A notice of intent to sue tolls the statute of limitations for medical malpractice claims, which is distinct from the Government Claims Act requirements. Because Harper failed to present her written claim to Modoc within a year after its accrual, the trial court lacked jurisdiction to provide relief under Government Code section 946.6.

MEDICAL BOARD DOESN'T SHOW GOOD CAUSE TO SUBPOENA PATIENT MEDICAL RECORDS IN INVESTIGATION OF PAIN MANAGEMENT SPECIALIST

Grafilo v. Wolfsohn *(April 2, 2019, No. BS171234) __ Cal.App.5th __ [2019 WL 1450733]*

The Department of Consumer Affairs (DCA), which oversees the Medical Board, investigated whether Dr. Marc Wolfsohn, a pain management specialist, was overprescribing opiate painkillers. Based on a report from the Controlled Substance Utilization Review and Evaluation System (CURES), investigators identified five patients who may have been prescribed excessive doses. The DCA served a subpoena duces tecum on Dr. Wolfsohn to produce more than two years of medical records for the five patients. After Dr. Wolfsohn objected on patient privacy grounds, the DCA secured an order compelling production. Dr. Wolfsohn appealed.

The Court of Appeal reversed, holding that the DCA had failed to demonstrate good cause for overriding the patients' privacy rights. The court explained that "the Medical Board must demonstrate through competent evidence that the particular records it seeks are relevant and material to its inquiry sufficient for a trial court to independently make a finding of good cause to order the materials disclosed." Here, DCA's evidence was inadequate because it failed to show "how many patients [Dr.] Wolfsohn treats, the percentage of his patients

the five patients comprised, how often similarly-situated pain management specialists might prescribe the drugs [Dr.] Wolfsohn prescribed, or the likelihood [Dr.] Wolfsohn properly issued the prescriptions." The DCA failed to contradict Wolfsohn's expert's declaration that "the prescriptions are 'not outside of acceptable' levels for a pain management specialist." The DCA also tried and failed to distinguish *Grafilo v. Cohanshohet* (2019) 32 Cal.App.5th 428, where it had likewise failed to establish good cause for compelling production of medical records because it was reasonable to assume that at least some patients required medication exceeding recommended dosages.