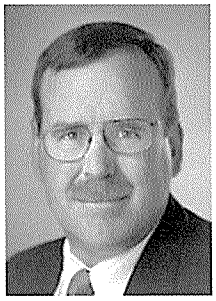
Appellate Case Summaries



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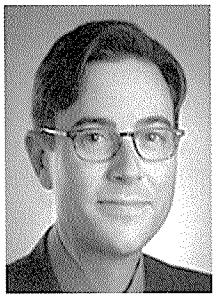

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MICRA LIMITATIONS PERIOD DOES NOT APPLY TO LAWSUIT IMPLICATING GENERAL DUTY TO MAINTAIN PREMISES SAFE FOR PUBLIC VISITORS

Johnson v. Open Door Community Health Centers (Sept. 11, 2017, A143992) __ Cal.App.5th __ [2017 WL 3976813]

A patient sued her health clinic, alleging that she suffered serious injuries after tripping on a weight scale that was moved by clinic staff during her visit. Because she filed suit nearly two years after the incident, the clinic moved for summary judgment arguing that the suit was time-barred by the Medical Injury Compensation Reform Act's (MICRA) one-year statute of limitations for negligence claims arising from "professional services." The patient argued that her suit was timely under the two-year statute of limitations for personal injury claims. The trial court agreed with the clinic, ruling that the MICRA limitations period applied because the patient was injured in the course of obtaining medical treatment, by equipment used to diagnose and treat medical conditions.

The Court of Appeal reversed, holding that the two-year statute of limitations for personal injury claims applied. The court explained that, under the Supreme Court's recent decision in Flores v. Presbyterian Intercommunity Hospital (2016) 63 Cal.4th 75, the MICRA limitations statute applies only to lawsuits alleging "professional negligence," i.e., those concerning obligations medical providers owe to their patients, as distinguished from obligations providers owe to the general public simply by operating public facilities. The MICRA limitations period did not apply here because the patient alleged she was injured when she tripped while exiting the facility after concluding her medical treatment, and those facts implicated a duty the clinic owed equally to all members of the public visiting its facility, not merely to those undergoing treatment.

HOSPITAL'S FAILURE TO RESPECT PATIENT AND GUARDIAN'S RIGHTS TO DECIDE MEDICAL CARE ISSUES SUPPORTS ELDER ABUSE LIABILITY

Stewart v. Superior Court (Oct. 12, 2017, E067316) __ Cal.App.5th __ [2017 WL 4544658]

Plaintiff sued a hospital, treating physicians, and others for wrongful death and other causes of action following the death of a patient who had given plaintiff his power of attorney for health care decisions. The hospital moved for summary adjudication of the Elder Abuse, fraud by concealment, and medical battery causes of action. Plaintiff opposed the motion, presenting evidence that the patient died following unauthorized and unnecessary cardiac surgery, and that the hospital had conducted a closed ethics committee meeting where the committee voided her power of attorney appointment and authorized the surgery to proceed.

The trial court granted summary adjudication for the hospital, ruling that (1) the Elder Abuse claim failed as a matter of law because the hospital's actions did not implicate custodial duties owed to the decedent; (2) the fraudulent concealment claim failed because the hospital owed no fiduciary duty to its patient; and (3) the medical battery claim failed because the physician who performed the surgery was not employed by the hospital. Plaintiff sought writ relief.

The Court of Appeal granted writ relief. In the published portion of its opinion, the court held the trial court erred by summarily adjudicating plaintiff's Elder Abuse cause of action. The court reasoned that the patient was a dependent adult who was in hospital custody and relied on the hospital to meet his fundamental needs. Moreover, the substantial impairment of a dependent adult's right to autonomy in the medical decision making process may constitute actionable "neglect" within the meaning of Welfare and Institutions Code section 15610.57, subdivisions (a)(1) and (2). Thus, a reasonable jury could find that the hospital recklessly or fraudulently failed to meet its custodial obligations toward its patient by authorizing surgery against plaintiff's consent at the ethics committee meeting where plaintiff was not allowed to participate (tending to support liability for Elder Abuse). In the unpublished portion of its opinion, the Court of Appeal held that the hospital could be liable for fraudulent concealment based on its failure to inform plaintiff of ethics committee meeting and the surgery it had authorized, and that it could be liable for medical battery based on evidence that it was sufficiently involved in allowing the surgery to be said to have " 'performed a medical procedure.' "

CLASS CERTIFICATION DENIED FOR CLAIM THAT HOSPITAL ILLEGALLY BILLED CHARGE MASTER RATES TO UNINSURED EMERGENCY PATIENTS

Kendall v. Scripps Health
(Oct. 18, 2017, No. D070390)
__ Cal.App.5th __ [2017 WL 4791986]

Paul Kendall, an uninsured patient, filed an action against Scripps Health asserting several class-wide claims challenging Scripps's billing and collection practices for emergency services to self-pay patients. When Kendall received emergency treatment at Scripps he had signed an agreement stating he was responsible for paying all billed charges as listed in the hospital's Charge Description Master. Scripps subsequently billed Kendall $17,511, the Charge Master rates for the services provided. Kendall sued Scripps, seeking injunctive relief from Scripps's alleged illegal billing and collection practices, as well as damages and restitution based on California's Unfair Competition Law (UCL) and the Consumer Legal Remedies Act (CLRA). The trial court denied Kendall's motion for class certification on the ground he had not demonstrated the proposed class was ascertainable or that common issues predominated. Kendall appealed.

The Court of Appeal affirmed the order denying class certification. First, the court affirmed the trial court's determination that common issues did not predominate. "[I]ndividualized inquiries would be necessary to calculate liability and damages, by generating a hypothetical reasonable rate for emergency services, and determining what portion of it each patient should be held liable to pay, after treatment was completed." Moreover, "numerous factors affect the amounts that will be sequentially billed, depending on later findings about availability of coverage from insurance, governmental benefits, charity or discounts." Second, the court affirmed the trial court's determination that the proposed class was not ascertainable because "Kendall did not show the existence of a reasonable method for Scripps 'to ascertain who has claims and who does not without an individualized analysis of each patient's payment record.' " Finally, the court rejected Kendall's argument that a class should be certified regarding his declaratory relief cause of action under federal law (using a FRCP 23 analysis). Application of federal law was unnecessary because Kendall had failed to identify any characteristics of the proposed class that could not properly be analyzed through the use of California law. Additionally, "[c]ertifying a class to issue declaratory relief . . . could not properly be granted in a theoretical vacuum that disregards not only the related substantive statutory claims, but also the existence of specialized regulations of emergency services billing that allow the use of the Charge Master format. Accordingly, the trial court did not abuse its discretion by determining that class certification was inappropriate.

NON-CONTRACTING PROVIDER WHOSE BILLS WERE CODED FOR NON-EMERGENCY SERVICES MAY NOT SEEK REIMBURSEMENT FOR EMERGENCY SERVICES

YDM Management Co. v. Sharp Community Medical Group, Inc. (Oct. 25, 2017, D071244) __ Cal.App.5th __ [2017 WL 4801570]

An urgent care facility assigned its accounts receivable to YDM Management Company, Inc. (YDM). YDM then sued Sharp Community Medical Group, an Independent Practice Association (IPA), seeking to recover additional reimbursement for emergency medical services that the urgent care facility had rendered to Sharp's managed care members. California regulations require IPAs to reimburse out-of-network providers for the full, reasonable, and customary value of emergency medical services, while nonemergency medical services are reimbursed at lower rates. The trial court granted Sharp's motion for summary judg-

ment. The court accepted Sharp's evidence that the urgent care facility's bills did not include Current Procedural Technology (CPT) codes that identify emergency services, and ruled that YDM had not controverted that evidence. YDM appealed.

The Court of Appeal affirmed, holding that the trial court properly found that the urgent care facility's bills included no emergency CPT codes, but instead used codes for non-emergency services—a binding concession that no emergency services had been provided. The trial court had excluded statements from YDM's proffered expert declaration that the urgent care facility bills sought reimbursement for emergency services, and the Court of Appeal affirmed that ruling because the expert's statements were conclusory and lacked foundation. Moreover, YDM's expert failed to dispute the dispositive fact that the urgent care facility bills did not include emergency services billing codes. Accordingly, Sharp was entitled to summary judgment.

TRIAL COURT PROPERLY REFUSES TO CERTIFY CLASS OF SELF-PAY PATIENTS CONTESTING HOSPITAL'S USE OF CHARGEMASTER RATES

Hefczyc v. Rady Children's Hospital-San Diego (Nov. 17, 2017, D071264) __ Cal.App.5th __ [2017 WL 5507854]

The guarantor of a minor self-pay patient filed a class action lawsuit seeking declaratory relief establishing that the Hospital's form contract, which allowed the Hospital to charge its "regular rates and terms," authorized the Hospital to charge only for the reasonable value of its services, rather than its inflated "Chargemaster" rates. Plaintiff sought to certify a class of "the guarantors of all persons who within the last four years, had one or more 'eligible patient hospital visits' to [the Hospital's] emergency department." The court refused on the grounds the class was not ascertainable, common issues did not predominate, and class action litigation was not a superior means of proceeding. The guarantor appealed from the denial of class certification.

The Court of Appeal affirmed. The guarantor had argued that the federal class certification rule, FRCP 23, should apply because he sought declaratory relief only. (The guarantor made this argument to try to avoid having to satisfy state-law ascertainability, predominance, and superiority requirements.) Citing its recent decision in Kendall v. Scripps Health (2017) 16 Cal. App.5th 553, which refused to apply FRCP 23 in an action for damages and restitution, the court explained that federal rules apply only in the absence of relevant state precedent. Here, the California Supreme Court has consistently required litigants seeking class certification to demonstrate ascertainability, predominance, and superiority and has never indicated it would diverge from those requirements in cases seeking only declaratory relief.

The Court of Appeal also held that the trial court did not abuse its discretion in determining that the class was not ascertainable, that common issues did not predominate, and that class action litigation was not a superior means of proceeding. Because the trial court would need to make individualized factual inquiries as to whether Chargemaster rates were reasonable as to each potential class member, common issues would not predominate and proceeding on a classwide basis would have been an inferior method of adjudication. The court also rejected the plaintiff's argument that the class was ascertainable because members of the public could self-identify as class members. The court reasoned that the public could not be expected to know whether they had been billed Chargemaster rates.

PSYCHOLOGIST MUST SUBMIT TO BOARD-ORDERED PSYCHIATRIC EXAM BEFORE CHALLENGING THAT ORDER

Fettgather v. Board of Psychology (Nov. 21, 2017, C074166) __ Cal.App.5th __ [2017 WL 6014163]

The California Board of Psychology investigated complaints about psychologist Robert Fettgather's behavior and communications with patients. When Fettgather refused to be interviewed, the Board ordered him to submit to a psychiatric examination under Business and Professions Code section 820. Fettgather then allowed the board's investigator to interview him, but he refused to submit to the ordered examination and did not appeal that order. Adopting the recommendation of an administrative law judge, the Board revoked Fettgather's license to practice psychology pursuant to Business and Professions Code section 821 and 2960. Fettgather petitioned for a writ of administrative mandamus challenging the revocation on the ground the Board had lacked good cause to order the psychiatric examination in the first place. The trial court declined to address Fettgather's argument, ruling that the only issue was whether Fettgather had failed to comply with the ordered examination, which was uncontested. Fettagther appealed, contending once again that the Board never had good cause to order the psychiatric examination.

The Court of Appeal affirmed. The court held that section 821 expressly permits the Board to revoke a license based on a practitioner's refusal to comply with an order issued under section 820, and that section 2960 also permitted the Board to revoke a license for this type of unprofessional misconduct. Accordingly, the board was not required to show good cause for issuing the section 820 order when it revoked Fettgather's license. The appellate court rejected Fettgather's separate constitutional challenges, holding that his due process rights were not impermissibly infringed by requiring him to submit to the ordered examination before challenging a formal accusation based on the results of that examination. The court explained that Fettgather's right to practice was not impeded by the section 820 order, and the Board had a compelling interest in requiring compliance with its section 820 orders to protect the public from mentally ill professionals, which would be severely compromised if practitioners were permitted to delay the Board's investigations. The court also rejected Fettgather's equal protection challenge, holding that California could permissibly subject licensed practitioners (but not the general public) to a compelled examination under section 820 because the licentiates were not similarly situated with the general public.

ATTORNEY-IN-FACT FOR HEALTH CARE DECISIONS MUST EXECUTE ADMISSION AGREEMENT WITH RESIDENTIAL CARE FACILITY PROVIDING DEMENTIA CARE TO ELDERLY RESIDENT

Hutcheson v. Eskaton FountainWood Lodge (Nov. 28, C074846) __ Cal.App.5th __ [2017 WL 5712590] [June 16, 2017 CSHA bulletin addressed the June 14, 2017 opinion, which was vacated by grant of rehearing and superseded by this opinion]

Decedent Barbara Lovenstein appointed her niece, Robin Hutcheson, as attorney-in-fact to make health care decisions under the Health Care Decision Law (Prob. Code, § 4600 et seq. (HCDL)), and appointed both her sister, Jean Charles, and Hutcheson as attorneys-in-fact for personal care matters under the Power of Attorney Law (Prob. Code, § 4000 et seq. (PAL)). Charles later admitted Lovenstein to Eskaton FountainWood Lodge, which is licensed as a residential care facility for the elderly under the California Residential Care Facilities for the Elderly Act (Health & Saf. Code, § 1569 et seq.). She executed an admissions agreement on Lovenstein's behalf that contained an arbitration provision.

Lovenstein later died after being hospitalized for aspiration pneumonia and severe dysphagia that she contracted after choking on food at FountainWood. Hutcheson and Charles sued FountainWood for elder abuse, fraud, and negligent infliction of emotional distress. The trial court denied FountainWood's petition to compel arbitration, ruling that the admission agreement was invalid because Charles' admission of Lovenstein to FountainWood was a health care decision beyond the scope of her authority as a personal care attorney-in-fact. FountainWood appealed.

The Court of Appeal affirmed, holding that Charles lacked authority to execute the admissions agreement because FountainWood agreed to provide Lovenstein with dementia care, a form of healthcare bringing the admissions agreement within the ambit of the HCDL. Because FountainWood had received the health care power of attorney naming Hutcheson as attorney-in-fact, and therefore knew that Charles lacked authority to make health care decisions for Lovenstein, FountainWood could not enforce the arbitration clause (since a known health care attorney-in-fact has priority over any other person to make health care decisions). The court explained that the scope of the HCDL is broad, and applies to facilities providing health care services, including dementia care, even if those facilities do not meet the narrower definition of health facility under MICRA and other statutes. (The court's initial decision affirmed the judgment, but the court granted rehearing and issued this new opinion, likewise affirming, to clarify what constitutes a "health care facility" and to explain that FountainWood knew Hutcheson had authority to make health care decisions.)