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

Miscoded bill does not automatically excuse health care service plan from paying for enrollee's emergency services

San Jose Neurospine v. Aetna Health of California, Inc. *(Feb. 27, 2020, B296716) __ Cal.App.5th __ [2020 WL 948123]*

A doctor with San Jose Neurospine (SJN) performed a lumbar microdiscectomy surgery on a patient insured by Aetna after the patient was taken to the emergency room with excruciating back pain. SJN submitted claims to Aetna for reimbursement for the medical services provided, but incorrectly cited non-emergency CPT (Current Procedural Terminology) codes. Aetna provided reimbursement for "non-emergency surgery." SJN sent Atena an appeal letter explaining its initial coding error, but Aetna declined to pay for the emergency services. SJN sued, alleging Aetna violated Health and Safety Code section 1371.4. Aetna moved for summary judgment, arguing that SJN was not entitled to reimbursement for emergency services because its initial bills contained non-emergency codes. SJN responded that its second bill mentioned "ER" and therefore requested reimbursement for emergency services, and filed evidence of the emergency services. The trial court granted Aetna's motion, reasoning that: "If the doctor doesn't submit the correct coding on a health insurance claim, he doesn't get paid for it." SJN appealed.

The Court of Appeal reversed, holding that "where the health care service plan knows that emergency services were in fact provided, a coding mistake on a billing claim does not automatically excuse or terminate its duty to pay for the services under [Health and Safety Code] section 1371.4, subdivision (c)." Here, there were triable issues about whether SJN's bills and its appeal letter alerted Aetna that SJN had provided emergency services. Aetna was unable to suggest an alternative meaning of the well-known abbreviation "ER" that appeared multiple times in the bills. SJN also produced declarations and deposition testimony showing it provided emergency services. The court concluded that a trier of fact could reasonably infer from this evidence that Aetna was on notice that SJN provided emergency services, or that Aetna ignored this evidence and denied reimbursement based on solely incorrect billing codes.

Medical negligence statute of limitations is triggered when a patient experiences appreciable harm reasonably causing her to suspect malpractice

Brewer v. Remington *(Mar. 4, 2020, F076467) __ Cal.App.5th __ [2020 WL 1059201]*

Judith Brewer sought medical treatment after she became paralyzed following carpal tunnel syndrome and shoulder surgery. After waiting a month for swelling to subside, Dr. Benjamin Remington performed spinal decompression surgery. But Brewer did not recover substantial function. Brewer filed a medical malpractice suit against her original surgeons, their medical group and facility, and Doe defendants. A year later, Brewer obtained medical charts and imaging through discovery; she sent them to a retained neurosurgical expert. The expert opined that Remington breached the standard of care by delaying her surgery for more than a month. Brewer then named Remington as a Doe defendant.

Remington moved for summary judgment on the ground that Brewer's lawsuit was barred by the 1-year statute of limitations (Code Civ. Proc., § 340.5), since she knew Remington's identity and the facts giving rise to her claim when he performed the unsuccessful spinal decompression surgery. The trial court granted Remington's motion. Brewer then moved for new trial, arguing that the court had erroneously failed to apply the delayed discovery rule. The court granted a new trial, ruling that whether Brewer should have discovered any injury as a result of Remington's medical treatment was a triable issue of material fact. Remington appealed.

The Court of Appeal affirmed. Code of Civil Procedure section 340.5 requires a plaintiff to sue within one year of discovering appreciable harm that the plaintiff suspects

or should suspect was caused by wrongdoing. Here, Brewer suffered a second injury by Remington's delay of the spinal surgery, and there was a factual issue regarding whether, more than a year before filing suit, she should have suspected that Remington had done something wrong. The mere persistence of Brewer's paralysis and loss of sensation did not necessarily constitute an appreciable manifestation of harm as a matter of law, and whether Brewer should have linked her persistent symptoms to wrongdoing by Remington presented a factual question. Moreover, simply because Remington's treatment did not resolve or more fully mitigate Brewer's injuries did not put her on inquiry notice that Remington provided negligent care. The lack of perfect treatment results cannot automatically trigger the statute of limitations for medical malpractice.

MICRA covers physician assistants that have enforceable agency agreements with supervising physicians

Lopez v. Ledesma (Mar. 24, 2020, B284452) __ Cal.App.5th __ [2020 WL 1429672]

Marisol Lopez took her infant daughter Olivia to a dermatology clinic owned by Dr. Glenn Ledesma to assess a spot developing on Olivia's scalp. Physician assistant Suzanne Freesemann examined Olivia and requested her insurer to approve an "excision and biopsy." Brian Hughes, another physician assistant at the clinic, saw Olivia one month later and performed a "shave biopsy" of the lesion. The doctor who examined the biopsied tissue found no malignancy. At a follow-up visit, Hughes noted that Olivia's biopsy wound was healing well and told Lopez that there was nothing to worry about. Several months later, Lopez noticed that Olivia's lesion was growing back and returned to the clinic. Freesemann assessed the new growth as "warts" and burned them off with liquid nitrogen. A few months later, Lopez brought Olivia back to the clinic because her lesion was "bigger, darker and not uniform in color." Hughes examined Olivia, concluded once again that the growth was warts, and referred her to a general surgeon to have them removed. A general surgeon excised the lesion and provided the tissue to a pathologist, who did not find any malignancy. About a year later, Olivia developed a bump on her neck. The surgeon removed the neck mass and referred her to an oncologist who diagnosed metastatic malignant melanoma. Olivia died shortly thereafter.

Lopez sued the physicians and the physician assistants for the wrongful death of her daughter. The trial court found that both Fresemann and Hughes had enforceable agency relationships with supervising physicians, but that they received little to no actual supervision and therefore failed to operate under required supervisory guidelines. The court further found that Freesemann and Hughes negligently failed to diagnose Olivia's condition or to seek needed physician guidance. The court awarded Lopez $11,200 in economic damages and $4.25 million in noneconomic damages, but reduced the noneconomic damages to $250,000 under the MICRA cap. (Civ. Code, § 3333.2, subd. (b).) The court rejected Lopez's argument that the MICRA limit was inapplicable to the physician assistants because they violated physician supervision regulations. Lopez appealed.

The Court of Appeal affirmed the application of the MICRA cap, in a split decision. Section 3333.2 limits the MICRA cap to "services . . . within the scope of services for which the provider is licensed . . . ." Lopez argued that the negligent physician assistants acted outside that scope—without the required supervision of a physician. The majority disagreed, holding that the physician assistants acted within the scope of their licenses by having legally enforceable agency agreements with a supervising physician regardless of the quantity, quality, or actuality of that supervision. MICRA's damages cap was therefore properly applied by the trial court. The dissent opined that physician assistants fail to practice within their license restrictions if they knowingly practiced autonomously without any meaningful physician supervision.

Disclosing the fact of psychotherapy treatment does not waive psychotherapist-patient privilege

Fish v. Superior Court (2019) 42 Cal.App.5th 811

Mason Fish was involved in an automobile accident that killed three people and severely injured three more. Fish told law enforcement that he was under the care of a psychotherapist who had prescribed antidepressant and antipsychotic medications to him. The prosecution charged Fish with gross vehicular manslaughter while intoxicated, and subpoenaed his psychotherapist's treatment records. Fish moved to quash the subpoena based on the psychotherapist-patient privilege. (Evid. Code, § 1014.) The prosecution countered that Fish's disclosure had waived the privilege and that its compelling prosecutorial need for the information outweighed the privilege. The trial court agreed with the prosecution, denied Fish's motion, and indicated it would conduct in camera review of the records to determine if Fish and his psychotherapist had discussed whether the medications might affect Fish's driving. The trial court postponed in camera review to allow Fish to seek writ relief.

The Court of Appeal granted writ relief. First, the court explained that "for policy reasons the psychotherapist-patient privilege is broadly construed in favor of the patient, while exceptions to the privilege are narrowly construed." The court held that Fish's mere disclosure to law enforcement that his psychotherapist had prescribed certain antidepressant and antipsychotic medications did not waive the privilege because the disclosure was not a "significant part" of his communications with his psychotherapist. And the court held that, when no waiver or exception to the privilege is established, the state's claimed compelling need for the information to help prosecution does not overcome the privilege. (See Menendez v. Superior Court (1992) 3 Cal.4th 435.) Accordingly, the Court of Appeal prohibited the trial court from reviewing Fish's psychotherapy treatment records in camera and ordered it to grant Fish's motion to quash the prosecution's subpoena of those records.

FCA claim may be pleaded by plausibly alleging false certifications of medical necessity

Winter ex rel. United States v. Gardens Regional Hosp. & Me. Ctr., Inc., __ F.3d __, 2020 WL 1329661 (9th Cir. Mar. 23, 2020)

Jane Winter was responsible for reviewing patient medical records at Gardens Regional Hospital and Medical Center to determine whether admission orders met the Hospital's medical necessity admission criteria. Shortly after a nursing home acquired ownership in the management company that oversaw operations at the Hospital, Winter alleges she noticed a spike in the number of emergency room patients transported from the nursing home—an overwhelming majority of whom were admitted for inpatient treatment. Believing this to be improper, Winter repeatedly tried to raise her concerns with hospital management, without success. Instead, she was instructed not to question the admissions, and then she was fired.

Winter brought a qui tam action under the False Claims Act alleging that the Hospital and affiliated persons submitted Medicare claims falsely certifying that patients' inpatient hospitalizations were medically necessary. The district court dismissed Winter's complaint for failure to plead a plausible claim, ruling that "to prevail on an FCA claim, a plaintiff must show that a defendant knowingly made an objectively false representation" and claims involving a doctor's clinical judgment can never state a claim under the FCA because "subjective medical opinions . . . cannot be proven to be objectively false." Winter appealed.

The Ninth Circuit reversed, explaining that "a plaintiff need not allege falsity beyond the requirements adopted by Congress" in the FCA, and Congress did not impose a requirement of proving "objective falsity." The FCA imposes liability for all "false or fraudulent claims" and does not distinguish between "objective" and "subjective" falsity, nor does it carve out an exception for clinical judgments and opinions. The Ninth Circuit further held that "a false certification of medical necessity can give rise to FCA liability" and can be "material because medical necessity is a statutory prerequisite to Medicare reimbursement." A doctor's certification that inpatient hospitalization was "medically necessary" can be false or fraudulent for the same reasons any opinion can be false or fraudulent. Thus, a medical necessity certification is actionable under the FCA if the opinion is not honestly held, or if it implies the existence of facts—namely, that inpatient hospitalization is needed to diagnose or treat a medical condition, in accordance with accepted standards of medical practice—that do not exist.

Arbitration agreement foreclosing an elder abuse claim is unenforceable

Dougherty v. Roseville Heritage Partners (Mar. 30, 2020, C087224) __ Cal.App.5th __ [2020 WL 1501701]

Lori Dougherty's demented father was removed from multiple care facilities and hospitalized. On the day he was released from the hospital, she contracted with Somerford Place, a residential care facility, to care for him. Dougherty had quickly toured Somerford and signed the admissions documents. A stand-alone arbitration agreement was included on pages 43 through 45 of a 70-page stack of admissions documents that Somerford was required by law to have Dougherty execute. After Dougherty's father died, she and her sister sued Somerford alleging elder abuse and wrongful death. The trial court denied Somerford's motion to compel arbitration, ruling that the arbitration agreement was both procedurally and substantively unconscionable. The court also declined to sever the unconscionable provisions and instead declared the entire arbitration agreement void. Somerford appealed.

The Court of Appeal affirmed. The court held the arbitration agreement procedurally unconscionable because Dougherty lacked meaningful choice, was insufficiently aware of the arbitration agreement and its limitations (due to its placement), and failed to provide Dougherty with copy of pertinent commercial arbitration rules. The court deemed these defects to reflect a high degree of procedural unconscionability, requiring a low level of substantive unconscionability to void the agreement.

Next, the court held that the agreement was substantively unconscionable, primarily because it contained discovery limitations that unreasonably favored Somerford, such as prohibiting depositions unless the arbitrator found good cause. The court reasoned that, because Dougherty's elder abuse claim required her to prove malicious intent (to recover heightened remedies), restricted discovery frustrated her statutory rights. Additionally, the agreement purported to eliminate punitive damages and attorney fees, which are available under the elder abuse statute. Finally, the agreement required Dougherty to waive a jury trial for disputes not covered by the agreement, in violation of California law.

Finally, the court held that trial court did not abuse its discretion in voiding the entire arbitration agreement—rather than striking only the offending provisions—because the agreement was highly unconscionable.

HHS reimbursement rule linked to low-income patient services improperly included Medicare-exhausted patients

Empire Health Found. v. Azar, __ F.3d __, Nos. 18-35845 & 18-35872 (9th Cir. May 5, 2020)

Under Medicare, hospitals that serve a disproportionate number of low-income patients receive a reimbursement for the higher costs incurred in providing those services. See 42 U.S.C. § 1395ww(d)(5)(F)(vi). Whether a hospital receives a reimbursement—and, if so, how much—depends on the hospital's "disproportionate patient percentage," which captures the number of Medicare- and Medicaid-eligible patient days for which the hospital provides services. Previously, Department of Health and Human Services rules included only "covered" patient days in calculating that percentage. But HHS promulgated a 2005 Rule that removed the word "covered" and thus included services provided to low-income patients who had exhausted their Medicare coverage.

Empire Health Foundation challenged the 2005 Rule under the Medicare Act's expedited judicial review provision, which implements the Administrative Procedure Act. The district court determined that the 2005 Rule was substantively valid, but procedurally invalid, and concluded the 2005 Rule should be vacated.

The Ninth Circuit affirmed on different grounds. The panel upheld the 2005 Rule's rulemaking process against Empire's procedural challenge based on the APA's notice-and-comment requirements. Though HHS did not resubmit the 2005 Rule for public comment after admitting errors in the notice, the 2005 Rule was still the logical outgrowth of the notice and provided fair notice to commenters. But the panel held that the 2005 Rule was substantively invalid. The text of the Medicare Act includes only those patients "entitled to" Medicare. And a previous Ninth Circuit opinion held that this language unambiguously refers to patients with an "absolute right" to payment. Legacy Emanuel Hosp. & Health Ctr. v. Shalala, 97 F.3d 1261, 1265-66 (9th Cir. 1996). That interpretation foreclosed the 2005 Rule because patients who have exhausted their coverage have no such right. Thus, the Ninth Circuit reinstated the pre-2005 rule, which includes only "covered" patient days.

Widow's inability to conceive due to tissue bank's loss of husband's sperm is not compensable absent evidence he intended posthumous conception

Robertson v. Saadat (May 1, 2020, No. B292448) __ Cal.App.5th __ [2020 WL 2109682]

Aaron Robertson entered into an irreversible coma due to a rare genetic disease. Prior to his death, Aaron's sperm was extracted and stored in defendants' tissue bank. When his wife, Sarah, requested the sperm 10 years later, the tissue bank was unable to locate it. Sarah sued the tissue bank for depriving her of the opportunity to have a child biologically related to her deceased husband. The trial court sustained demurrers, ruling that Sarah was not legally entitled to use her husband's sperm for posthumous conception and, accordingly, suffered no injury.

The Court of Appeal affirmed. First, the court held that Sarah's status as Aaron's widow did not entitle her to conceive using his sperm. The court reasoned that, because sperm is unique and not governed by general laws relating to gifts, the donor's intent (not a plaintiff's status) controls its disposition. Absent affirmative indications to the contrary, courts will presume that a decedent did not intend his or her gametic material to be used for posthumous conception. Sarah's allegations that Aaron had expressed a desire to have children with her failed as a matter of law to evince consent to posthumous conception. The court also rejected Sarah's argument that "transplantation" under the Uniform Anatomical Gift Act included conception. The court concluded the Act is limited to replacing damaged or lacking organs and tissue. Absent any entitlement to use Aaron's sperm for posthumous conception, Sarah had no cognizable tort or contract damages based on her inability to conceive.

Anti-SLAPP statute protects hospital's statements about doctor's qualifications and competence

Yang v. Tenet Healthcare Inc. (May 8, 2020, E071693) __Cal.App.5th__ [2020 WL 2299450]

Doctor Suzanne Yang sued a Tenet hospital and members of its medical staff for defamation based on alleged statements they made about her qualifications, competence, and medical ethics. The statements were made both to the public and the medical community. Defendants' alleged statements denigrated Dr. Yang's ethics and her standard of care; they also directed other physicians not to refer patients to her. Defendants filed an anti-SLAPP motion arguing that their statements were protected. The trial court denied the motion, ruling that the statements were not covered by the anti-SLAPP statute because they did not arise from the exercise of free speech about a matter of public interest, and that even if they were covered, Dr. Yang established a probability of prevailing on the merits. Defendants appealed.

The Court of Appeal reversed, following the Supreme Court's recent anti-SLAPP decision in *FilmOn.com Inc. v. DoubleVerify, Inc.* (2019) 7 Cal.5th 133. First, the court held that defendants' speech regarding Dr. Yang's "qualifications, competence, and professional ethics" directly concerned the public issue of physician competency. Second, the court found a "functional relationship" between the statements and the public issue: defendants contributed to the public debate on a doctor's qualifications by making statements to the public, not just to the medical staff. Finally, the Court of Appeal held that Dr. Yang failed to meet her burden of proving the likely merits of her defamation claim. Dr. Yang's evidence concerned statements that were made two years before her action was filed, well outside the one-year limitations period. Additionally, her allegations that the comments continued "until the present" were speculation, not admissible evidence that could support her claim.

Religious employer's constitutional challenge to DMHC abortion coverage directive was justiciable

Skyline Wesleyan Church v. Cal. Dep't of Managed Health Care, __ F.3d __, 2020 WL 2464926 (9th Cir. May 13, 2020)

Skyline Wesleyan Church filed suit against the California Department of Managed Health Care and its Director (collectively, the "DMHC") after the DMHC issued letters to seven health insurers mandating that their insurance plans include coverage for legal abortions. Until the DMHC's directive, Skyline had obtained DMHC-approved health insurance for its employees that restricted abortion coverage consistent with Skyline's belief that abortion is impermissible except possibly when the life of a pregnant woman is at risk. Skyline alleged that the DMHC's abortion coverage requirement unlawfully interfered with its right to the free exercise of religion and other constitutional rights. Skyline sought declaratory relief, a permanent injunction against the abortion coverage requirement, and an award of nominal damages, costs, and attorney fees. The district court granted the DMHC summary judgment without reaching the merits, ruling that Skyline lacked standing and that the controversy was not ripe because the DMHC had not yet received a request for approval of an insurance plan consistent with Skyline's religious beliefs. Skyline appealed.

The Ninth Circuit reversed, holding that Skyline's Free Exercise Clause claim is justiciable. Skyline suffered an injury in fact because it lost its abortion-excluded insurance coverage that was in place before the DMHC sent its directive. The DMHC's directive requiring insurers to change their coverage

caused that loss when Skyline's insurer complied with that directive. The alternative plans available to Skyline were a worse fit for its needs than a DMHC-approved plan. And Skyline's claims for nominal damages, declaratory relief, and a permanent injunction would redress its claimed loss. Turning to ripeness, the court reversed because the DMHC's directive had an immediate effect upon Skyline: its insurer promptly amended Skyline's plan (to comply with the directive). The court held that Skyline's "challenge is fit for a decision now" and that Skyline need not first seek an exemption from the DMHC or enlist an insurer to seek one.

The Ninth Circuit declined to reach the merits of Skyline's Free Exercise claim, which the district court had never addressed. After oral argument on appeal, the Supreme Court granted a petition for writ of certiorari questioning whether Employment Division v. Smith, 494 U.S. 872 (1990) should be revisited, and Skyline's Free Exercise Clause claim turned on Smith. Accordingly, the Ninth Circuit remanded to the district court to determine whether Skyline's other claims were justiciable, and then to decide the merits of Skyline's justiciable claims.

Conclusory expert declaration that lacks foundation does not create a triable issue regarding causation

Lowery v. Kindred Healthcare Operating, Inc. (May 18, 2020, A153421) __ Cal. App.5th __ [2020 WL 2520173]

Ruth Goros sued Kindred Healthcare, which operated the nursing home where she lived, for failing to provide timely treatment after she suffered a stroke. Goros argued that Kindred's negligence caused her "permanent and irreversible [and eventually fatal] brain damage." Kindred moved for summary judgment as to causation, supporting its motion with a neurologist's declaration that Kindred's conduct was unrelated to Goros's injuries. According to Kindred, due to significant medical co-morbidities, "medical intervention to reverse the stroke was not medically possible." Goros opposed summary judgment with a declaration from Dr. Lawrence Miller, an "expert in physical medicine, rehabilitation, geriatrics, and pain disorders." He declared that timely medical intervention to dissolve Goros' blood clot "would have provided the opportunity to have the effects of the stroke dramatically reduced and the severity of the stroke would not have contributed to the cause of her death like it did in this instance." The trial court sustained Kindred's objection to Dr. Miller's declaration, ruling that he was not qualified to testify about the cause or treatment of Goros's injury.

The Court of Appeal affirmed, holding that the trial court properly followed Sargon Enterprises, Inc. v. University of Southern California (2012) 66 Cal.4th 747 (Sargon) to exclude Dr. Miller's declaration. The court explained that Dr. Miller's "vague reliance on 'documented medical literature' " for his "conclusory" opinion was inadequate. The court further held Goros "failed to show that Dr. Miller's qualifications extend to the specific [neurological] opinions he expressed here." Finally, the court rejected Goros's argument that she should have been permitted to submit a supplemental declaration establishing the missing foundation for Dr. Miller's opinion, both because she never requested leave to do so and because she had adequate time to prepare her opposition.

[**Editors' Note:** It appears that Dr. Miller's opinion about a missed "opportunity" to reduce the effects of the stroke was flawed in another, unmentioned respect. It rested on the "lost chance theory of causation" that has "been uniformly rejected in California 'as contrary to sound logic, legal precedent[,] and public policy.' " (*Williams v. Wraxall* (1995) 33 Cal.App.4th 120, 134-135; accord, *Bromme v. Pavitt* (1992) 5 Cal.App.4th 1487, 1504, 1506-1508; Dumas v. Cooney (1991) 235 Cal. App.3d 1593, 1608-1611.) "[T]here exists an obvious distinction between a reasonable medical probability and a medical possibility. [Citation.] There can be many, even an infinite number of, possible circumstances which can produce an injury. But a 'possible cause only becomes "probable" when, in the absence of other reasonable causal explanations, it becomes more likely than not that the injury was a result of its action. This is the outer limit of inference upon which an issue may be submitted to the jury.' " (*Simmons v. West Covina Medical Clinic* (1989) 212 Cal.App.3d 696, 702, citing *Jones v. Ortho Pharmaceutical Corp.* (1985) 163 Cal.App.3d 396, 403; see generally Watson, Determining Whether Medical Causation Is Established Using Statistical Analysis [horvitzlevy.com] (Feb. 2010) Law Journal Newsletters; Perrochet, Smith & Colella, Lost Chance Recovery and the Folly of Expanding Medical Malpractice Liability [horvitzlevy.com](1992) 27 Tort & Ins. L.J. 615.)]