H. Thomas Watson
Horvitz & Levy, LLP

Peder K. Batalden
Horvitz & Levy, LLP

UTILIZATION REVIEW PHYSICIAN OWES THE INJURED WORKER A DUTY OF CARE AND MAY BE LIABLE FOR CAUSING A NEW INJURY OR AGGRAVATING AN EXISTING INJURY

King v. CompPartners, Inc. (Jan. 5, 2016, E063527) ___ Cal.App.4th ___ [2016 WL 55505]

Plaintiff Kirk King was prescribed the psychotropic medication Klonopin by his treating physician to treat anxiety and depression associated with his 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 then sued Dr. Sharma and CompPartners, Inc. (Dr. Sharma's employer) under various tort theories, alleging that he suffered seizures due to the immediate withdrawal of the Klonopin that Dr. Sharma's negligence caused. The trial court sustained the defendants' demurrer without leave to amend, ruling that King's claims were preempted by the Workers' Compensation Act (WCA) because they arose out of a utilization review decision, and that the defendants did not owe King any duty of care because Dr. Sharma was not King's treating physician and did not prescribe the Klonopin.

The Court of Appeal affirmed the sustaining of the demurrer, but reversed the denial of leave to amend. The court first addressed the preemption issue, explaining that injuries arising in the course of the workers' compensation claims process are preempted by the WCA because this process is " 'tethered to a compensable injury.' " However, if a new injury arises, or the prior workplace injury is aggravated, due to a mishap during the claims process, then preemption may not apply. The court interpreted King's complaint as alleging that his seizure arose either (1) from Dr. Sharma's incorrect determination that Klonopin was unnecessary, when in fact a reduced dosage was needed to wean Kirk off of the medication, or (2) from Dr. Sharma's failure to warn of the dangers of an abrupt withdrawal from Klonopin. The court held the first option was a challenge to Dr. Sharma's medical necessity determination, which is part of the claims process and therefore preempted. The second option, however, was not preempted because warning of the dangers of an abrupt withdrawal falls outside the medical necessity determination of the utilization review process. Therefore, because there was a possibility Kirk's tort causes of action were not preempted, the court held the trial court erred by denying leave to amend.

Finally, the court held that, under Palmer v. Superior Court (2002) 103 Cal. App.4th 953, there is a doctor-patient relationship between a utilization review doctor and the person whose medical records are being reviewed. While this meant Dr. Sharma owed Kirk a duty of care, it did not necessarily mean that Dr. Sharma was liable for Kirk's injury—the scope of duty depends upon the facts of the case. Kirk's complaint did not contain sufficient facts pertinent to the scope of the duty owed, so the Court of Appeal held that the trial court should have granted King leave to amend his

complaint. The court concluded it was possible that Kirk could allege additional facts supporting a conclusion that, under the circumstances, Dr. Sharma owed a duty to warn about or protect King from the risk of seizures.

PHYSICIAN MANAGEMENT COMPANY DID NOT ENGAGE IN CORPORATE PRACTICE OF MEDICINE BY CHARGING FEES COMMENSURATE WITH SERVICES

Epic Medical Management, LLC v. Paquette (Dec. 29, 2015, certified for publication on Jan. 28, 2016, B261541) ___ Cal.App.4th ___ [2015 WL 9920240]

Dr. Paquette contracted with Epic to supply non-medical management services to his practice. Under their contract, Epic leased office space and equipment to Dr. Paquette, provided nurses (whom Dr. Paquette trained and supervised), implemented a marketing plan, conducted billing and collections, and performed accounting services. The contract required Dr. Paquette to pay Epic a management fee amounting to 120 percent of the aggregate monthly costs Epic incurred (subject to certain modifications). The parties performed under the contract for more than three years, but Epic was never paid 120 percent of its incurred costs. Instead, Epic charged, and Dr. Paquette paid, a fee calculated as 50 percent of what Dr. Paquette charged for office medical services, 25 percent of his surgical service charges, and 75 percent of pharmaceutical expenses.

After the contract was terminated early, Epic sued Dr. Paquette for unpaid fees, and Dr. Paquette filed a cross-complaint, alleging that Epic had under-performed its duties under the contract and owed him money. The contract contained an arbitration clause, so the dispute proceeded to arbitration, where an arbitrator ruled in favor of Epic. The arbitrator found the parties had, by their conduct, modified the contract so that Epic was entitled to fees on a 50-25-75 basis, rather than to 120 percent of aggregate costs under the written agreement. The parties moved to confirm and vacate the award, respectively. Of particular interest, Dr. Paquette argued that the 50-25-75 approach violated the law against the corporate practice of medicine. (See Bus. & Prof. Code, § 650.) The trial court rejected the argument and ruled for Epic, confirming the arbitration award.

The Court of Appeal affirmed, applying the narrow review that governs arbitration awards. The court concluded that the award could not be reviewed for illegality on arbitration review, but that in any event the contract was not illegal as a matter of law. Paquette's contention that the payments to Epic constituted an illegal kickback scheme (under section 650) for referring patients was rejected. The court held that section 650, subdivision (b), permits contracts between physicians and non-physicians in which compensation is based on a percentage of gross revenue—as long as the consideration is commensurate with the services rendered, or the facilities and equipment provided. The court concluded that Epic's services were commensurate with its payments, thereby avoiding the prohibition in section 650. The Court of Appeal also rejected Dr. Paquette's argument that the contract was illegal as a whole, since referrals by other doctors (through Epic) to Dr. Paquette amounted only to a small percentage of Dr. Paquette's patients during the period when Epic was the manager. (Finally, the court addressed and rejected two other grounds for vacating the arbitral award.)

IPA IS NOT LIABLE FOR THE COST OF TESTING SPECIMENS THAT PHYSICIANS MISDIRECT TO NON-CONTRACTED LABORATORIES

Unilab Corporation v. Angeles-IPA (Jan. 13, 2016, B255136) __ Cal. App.4th __ [2016 WL 374988], ordered published Feb. 1, 2016

This case holds that an independent physician association (IPA) is not responsible for the cost of laboratory tests on specimens that were misdirected to non-contracted laboratories due to physician oversight or error. Angeles is an IPA that contracts both with health plans to provide health care services to plan enrollees, and with health care providers (including physicians and laboratories) to provide medical services to the enrollees. Quest had contracted with Angeles to provide clinical laboratory and testing services. Physicians would obtain specimens from patients and place them (along with the patient's IPA information) in a Quest-provided drop box located at the physician's office. Quest collected specimens and tested them, but did not confirm the identity

of the patient's IPA until after testing. Angeles later terminated its contract with Quest and directed its in-network physicians to send all specimens to a different contracted laboratory. But some physicians continued to place Angeles patients' specimens in Quest drop boxes by mistake. In those instances, Quest performed the tests before discovering it was not an approved provider for the patients' IPA.

Angeles refused to pay Quest for this work. Quest sued Angeles, primarily on theories that (1) Angeles was liable under an agency theory for the tests ordered by Angeles-contracted physicians; (2) Quest was entitled to restitution based on unjust enrichment; and (3) the contracts between Angeles and the health plans created a binding legal obligation to pay Quest for its work. The superior court rejected each theory and entered summary judgment for Angeles.

The Court of Appeal affirmed. First, the court rejected Quest's agency argument that an implied-in-fact contract was created when an Angeles-contracted physician placed a specimen for testing in a Quest drop box. Angeles lacked control over the physician-patient relationship and could not prevent doctors from sending patients' specimens to out-of-network laboratories. Although the physicians' independent contractor agreement with Angeles stated they were providing services "on behalf of" Angeles, construing that term to make the physicians *agents* of Angeles would improperly nullify the *independent contractor* agreement. Moreover, Angeles had never agreed to pay for unauthorized tests. Fault lay with the physicians that had erroneously used Quest drop boxes. Next, the court rejected Quest's argument that Angeles was liable for unjust enrichment because there was no evidence that Angeles benefited from the unauthorized tests. The court refused to indulge Quest's speculation that the unauthorized tests had enabled Angeles to enter into more lucrative contracts with its in-network laboratories (who would not have to perform the work erroneously directed to Quest while reaping fees on a capitation or flat-fee basis). Finally, the court held there was no basis in the Knox-Keene Act or other statutes to hold Angeles liable under these circumstances.

DOCTORS OWED NO DUTY TO REPORT DOMESTIC ABUSE RESULTING IN DEATH WHEN THEY LACKED REASONABLE SUSPICION OF ABUSE

Pipitone v. Williams (Feb. 23, 2016, H041468) __ Cal.App.4th __ [2016 WL 718475]

Ryann Bunnell was killed by her husband, Jesse Crow, who later killed himself in jail while awaiting murder charges. Several months before Ryann's death, Dr. Crow (Jesse's father, a retired physician), and Dr. Williams (a friend of the Crow family and an orthopedic surgeon), separately treated Ryann for injuries sustained when Jesse ran over her foot with his truck. Ryann did not reveal the true origin of her injuries to either physician. Neither physician suspected or reported abuse to the police, but Ryann's mother, Pam Pipitone, and another relative made a report, which was investigated by police. After Jesse murdered Ryann, Pipitone filed a wrongful death action against Drs. Crow and Williams for failing to report suspected abuse under Penal Code sections 11160 and 11161, which together mandate a prompt report to law enforcement when a physician acting in a professional capacity provides medical services to a patient "whom he or she knows or reasonably suspects" is "suffering from any wound or other physical injury . . . where the injury is the result of assaultive or abusive conduct."

The trial court granted summary judgment in favor of both physicians, and the Court of Appeal affirmed. The Court of Appeal declined to accept Dr. Crow's threshold argument that he owed no duty under the statutes because he had acted as a parent, not "in a professional capacity," when treating Ryann. But the court nonetheless concluded that Pipitone failed to elicit evidence creating a triable issue that Dr. Crow should reasonably have suspected abuse. The Court of Appeal declined to consider Pipitone's expert witness testimony on the signs of domestic abuse. And although Dr. Crow was aware that Jesse had a temper, a history of fights, and was noticeably intoxicated on the night of the incident, the court concluded that this evidence taken together did not show that Dr. Crow knew or reasonably suspected that Ryann's foot injury "was the result of assault or abuse." Similarly, the trial court concluded Pipitone failed to show Dr. Williams had any reason to suspect

abuse. Dr. Williams saw Ryann later, at a clinic, and Ryann did not reveal what happened when she was injured. Because her injuries were consistent with her report that a truck with an unidentified driver ran over her foot, Dr. Williams should not reasonably have suspected abuse.

Finally, after concluding that the physician defendants owed no duty of care, the Court of Appeal went on to discuss why Pipitone could not establish causation either. When Ryann's family reported their abuse suspicions to police, Ryann refused to cooperate with the investigating officer. Even so, the matter was investigated by police, and the court held for that reason that the tragic outcome would not have been averted even if one of the physicians had reported abuse.

PRODUCTION OF PATIENT MEDICAL RECORDS COMPELLED BECAUSE MEDICAL BOARD'S INTEREST IN PROTECTING PUBLIC HEALTH OUTWEIGHED PRIVACY INTERESTS IN THE RECORDS

Fett v. Medical Board of California (Feb. 3, 2016, B262469) ___ Cal. App.4th ___ [2016 WL 424705], ordered published on Feb. 26, 2016

Dr. David R. Fett, an ophthalmic plastic surgeon, appealed a trial court's decision to enforce an administrative investigative subpoena issued by the Medical Board of California (the Board) that sought the medical records of three patients. The Board had received a complaint from Stacey Wagley, an investigator at OptumInsight (a company that facilitates electronic transactions between insurance carriers, health care providers, and medical facilities), alleging that Dr. Fett may have billed for services he did not render and paid funds to which he was not entitled. After reviewing Ms. Wagley's investigative file (which included incomplete versions of the three patients' medical records), Dr. Erich W. Pollak, the Board's consultant, concluded that Dr. Fett may have breached the standard of care by (1) failing to safeguard medical records; (2) failing to obtain informed consent; (3) operating without written consent; (4) failing to properly document billings; (5) altering medical records; and (6) misrepresenting the complexity of procedures. However, Dr. Pollak opined that it was necessary to obtain the patients' complete medical records to make an accurate determination of these possible breaches. Despite all three patients objecting to the release of their records and indicating they were satisfied with Dr. Fett's care, the trial court compelled Dr. Fett to comply with the subpoena (as limited to three years of records). On appeal, Dr. Fett argued (1) there was not good cause to invade the patients' right to privacy of their medical records, (2) the patients' right to privacy outweighed the Board's interest in the records, and (3) the subpoena was impermissibly overbroad.

The Court of Appeal affirmed. First, the court held that substantial evidence supported the trial court's finding that good cause existed for compelling production of the records. Among other deficiencies, consent forms were missing, had irregular signatures, and/or lacked witnesses, and bills lacked documentation, appeared altered, or failed to support the services billed. The court agreed with Dr. Pollak that the patients' complete files were needed to determine whether records were missing or altered, whether Dr. Fett ever operated without patient consent, and whether complete operative reports were prepared. Dr. Fett challenged Dr. Pollak's report on the ground he was not an ophthalmic plastic surgeon. But the court held that Dr. Pollak was qualified to competently opine about general standards of surgical practice. Dr. Fett also argued that Ms. Wagley's investigative file could not support the Board's investigation because she violated patient medical confidentiality protected by Civil Code section 56.26 when she provided the Board with patient records. The Court of Appeal disagreed, holding that no exclusionary rule prevents improperly obtained evidence from being used to launch an administrative investigation. Finally, the Court of Appeal held the government's compelling interest in protecting the public—by ensuring that medical care provided by Board-certified practitioners meets the industry's standard of care—outweighs these patients' privacy interests, and that the subpoena was not overbroad because the court limited it to three years of records.

ERISA PREEMPTS STATE LAW REQUIRING HEALTHCARE COST REPORTING

Gobeille v. Liberty Mutual Ins. Co., 577 U.S. ___, 2016 WL 782861 (Mar. 1, 2016)

Vermont—like 18 other states (but not California)—has enacted a scheme of statutes and regulations requiring certain healthcare organizations that pay for medical services (including self-funded group health plans and their third-party administrators) to report to the state all "information relating to healthcare costs, prices, quality, utilization, or resources." The state gathers this data and maintains a database monitoring healthcare quality and costs. Liberty Mutual operates a self-insured health plan (covered by ERISA) using Blue Cross as its third-party administrator. Vermont issued a subpoena requiring Blue Cross to provide the statutorily required information about healthcare services utilized by Liberty Mutual participants. Liberty Mutual challenged Vermont's reporting scheme as preempted by ERISA. The district court ruled for Vermont, but a divided panel of the Second Circuit reversed, holding that ERISA preempted the state reporting scheme.

The U.S. Supreme Court affirmed. The six-Justice majority opinion focused on ERISA's broad preemption of state laws that govern, or interfere with the uniformity of, plan administration. ERISA ensures that employees' benefits are secure, in part by implementing oversight procedures that include extensive reporting, disclosure, and recordkeeping requirements. Because the Vermont scheme also governed reporting, disclosure, and recordkeeping requirements (though arguably in a different sense), the Vermont scheme threatened to impose on ERISA plans novel, inconsistent, or burdensome reporting requirements that could conflict with requirements imposed by other states. The Court therefore held that ERISA preempted the state scheme.

In a concurring opinion, Justice Breyer noted that the Secretary of Labor (and potentially the Secretary of Health and Human Services) seemingly have the authority to create reporting requirements like those in Vermont that would not offend ERISA. In a dissenting opinion, Justice Ginsburg (joined by Justice Sotomayor) argued that ERISA should not preempt the Vermont statute because the two schemes serve different purposes: Vermont's law aims to control overall healthcare quality through widespread disclosure of costs, while ERISA seeks to hold benefit plans to the terms of their obligations to participants.

Though California lacks a mandatory reporting system like Vermont's scheme, California does have a voluntary reporting system in place—the California Healthcare Performance Information System. Nothing in Gobeille indicates that such a voluntary reporting system would be preempted by ERISA.

FORMER MANUFACTURER OF A NAME-BRAND DRUG WHO HAD AN INADEQUATE WARNING MAY BE LIABLE FOR HARM CAUSED BY LATER OFF-LABEL USE OF A GENERIC FORM OF THE DRUG

T.H. v. Novartis Pharmaceuticals Corp. (Mar. 9, 2016, D067839) __ Cal.App.4th __ [2016 WL 916387]

Novartis obtained a license to manufacture and market terbutaline, an FDA-approved medication for the treatment of asthma, under the brand-name Brethine. In addition to its use as an asthma medication, terbutaline was widely prescribed to pregnant women as a tocolytic treatment to prevent or inhibit preterm labor. However, multiple studies and trials beginning in the late 1970s and continuing into the 2000s showed the drug was ineffective at inhibiting labor, was potentially dangerous to the mother and fetus, and could interfere with fetal development.

In 2001, Novartis sold its rights to produce and market Brethine. More than a decade later, twin minors sued Novartis under a negligent failure to warn theory for injuries they allegedly sustained in utero after their mother was prescribed a generic form of terbutaline in 2007. The trial court sustained Novartis's demurrer without leave to amend, ruling that Novartis owed plaintiffs no duty of care as a matter of law.

The Court of Appeal reversed, holding that plaintiffs demonstrated they could amend their complaint to state viable

claims for negligent failure to warn and negligent misrepresentation. Specifically, the court concluded that plaintiffs could allege that Novartis had sufficient information before 2001 about how using turbutaline as a tocolytic treatment was dangerous to fetal development; on that basis, Novartis could have revised the drug's warnings to indicate that risk, and the mother's physician would not have prescribed the drug had Novartis given that warning. The court agreed with Conte v. Wyeth, Inc. (2008) 168 Cal.App.4th 89, that a brand-name pharmaceutical manufacturer may be held liable for injuries caused, at least in part, by its negligent dissemination of inaccurate information. Although the patient consumed a generic version of the medication, generic drug manufacturers are required by federal law to use a label that is identical to the brand-named label. The T.H. court extended the Conte holding to name-brand manufacturers who sold their drug rights prior to the injury. The court reasoned that "the chance of preventing future harm is increased by imposing a duty on pharmaceutical manufacturers to warn based on medical and scientific evidence available to them as long as they own a product line and are responsible for labeling under the FDA requirements" and "Novartis's moral culpability [for an inadequate drug label] is not lessened simply because it no longer owned the [rights to the named-brand drug] when the minors were allegedly harmed" by the generic form of the medication ingested by their mother.

ALLEGATIONS THAT INSURER AUTHORIZED HOSPITAL SERVICES BEFORE DENYING COVERAGE SUPPORT FRAUD AND OTHER CAUSES OF ACTION

Tenet Healthsystem Desert, Inc. v. Blue Cross of California (Mar. 17, 2016, D069057) __ Cal.App.4th __ [2016 WL 1056521]

A Tenet hospital sued Anthem Blue Cross for fraud and related causes of action after Anthem refused to pay almost $2 million in medical services that Hospital provided to a patient covered by an ERISA benefits plan administered by Anthem. Hospital's complaint alleged that its patient was severely injured in a car accident. Over the next two months, Anthem representatives repeatedly "authorized" Hospital to provide the patient with needed services. Months later, however, Anthem denied coverage based on an exclusion in the patient's health insurance policy for injuries sustained as a result of driving with a blood alcohol level over the legal limit. Hospital's complaint alleged that Anthem's continuous "authorization" of medical services, even after Anthem knew that the patient was admitted with a blood alcohol level far exceeding the legal limit, constituted a misrepresentation as to coverage, on which Hospital reasonably relied in providing services. The trial court sustained Anthem's demurrer without leave to amend, concluding that Hospital failed to plead its misrepresentation causes of action with the requisite degree of specificity.

The Court of Appeal reversed. The court held that Hospital's fraud cause of action survived a demurrer because it was supported by sufficient allegations regarding numerous communications from Anthem's representatives that had authorized Hospital's services to the patient. Specifically, the complaint recited when those Anthem representations were made, where they were made, to whom they were made, the means by which they were made, and named some of the Anthem representatives who made them, including an Anthem discharge planner who requested Hospital to admit the patient to its rehabilitation facility upon discharge from the ICU.

The court also found the trial court failed to consider that a fraud cause of action "may arise from conduct that is designed to mislead, and not only from verbal or written statements." Hospital alleged repeated conduct over a two-month period, including Anthem's inquiries regarding the medical necessity of the patient's treatment, that implied the services authorized by Anthem and provided by Hospital were not only medically necessary, but were insured. Finally, the court held that the allegations supporting the fraud claim likewise supported of other common law and statutory claims, including negligent misrepresentation and unfair business practices.

MEDICAL BOARD MAY NOT SUBPOENA PATIENT'S MEDICAL RECORDS WHILE INVESTIGATING PSYCHOTHERAPIST'S ALLEGED SEXUAL MISCONDUCT ABSENT COMPELLING JUSTIFICATION

Kirchmeyer v. Phillips (Mar. 28, 2016, G051594) ___ Cal.App.4th ___ [2016 WL 1183324]

The California Medical Board, through Executive Director Kimberly Kirchmeyer, investigated Dr. Geoffrey Phillips, a licensed psychiatrist, based on an allegation that he had a sexual relationship with one of his patients, A.M. After her therapy with Dr. Phillips ended, A.M. divorced her husband, S.M. S.M. then filed a complaint with the Medical Board alleging that Dr. Phillips and A.M. had a sexual relationship during her treatment. The Medical Board issued a subpoena duces tecum to Dr. Phillips requesting A.M.'s medical records. He refused, and both he and A.M. objected to disclosure of her medical records. The Board then petitioned the trial court to compel production. After reviewing the records in camera, the trial court denied and dismissed the petition, and the Board appealed.

The Court of Appeal affirmed, explaining that although the Medical Board has the authority to issue subpoenas when investigating a physician's misconduct under Government Code section 11181, this subpoena power is limited by the psychotherapist-patient privilege and A.M.'s constitutional right to privacy. Accordingly, the Board was required to establish a compelling state interest supporting her demand for production of A.M's medical records.

The Court of Appeal acknowledged that the Medical Board established a "valid and significant" state interest in ensuring patients' safety and investigating doctors accused of sexual misconduct with their patients. Indeed, it is unprofessional and criminal misconduct for a psychotherapist to have sexual relations with a patient (including former patients whose therapy ended for the purpose of engaging in the sexual relationship, unless they have been referred to an independent therapist)—regardless of the patient's consent. Nevertheless, the Court of Appeal affirmed the order denying production of A.M.'s medical records because the Board had access to other evidence regarding the inappropriate relationship and A.M's medical records were unlikely to document the relationship. Moreover, the court noted that the trial court had reviewed the records in camera and determined A.M.'s privacy interests outweighed the Board's interest in production, and there was "no reason to second-guess the trial court's conclusion." The Board also argued that production should be compelled because (1) records sought in connection with a disciplinary investigation are not privileged pursuant to Business and Professions Code section 2225, subdivision (a), and (2) she had a compelling interest in production based on "transference" (a phenomenon in which a patient falls in love with her therapist). The Court of Appeal held that the Board had waived both arguments by not adequately presenting them to the trial court. Finally, the court held that the "in-issue" exception to the psychotherapist-patient privilege (in Evidence Code section 1020) did not support production because it applies only when the holder of the privilege (i.e., Dr. Phillips or A.M.) places the protected material at issue themselves.

ELDER ABUSE LIABILITY MAY BE PREMISED ON HOSPITAL'S KNOWING PATTERN OF UNDERSTAFFING IN VIOLATION OF REGULATIONS

Fenimore v. Regents of the University of California (Mar. 9, 2016, B262186) ___ Cal.App.4th ___ [2016 WL 891841], ordered published Mar. 28, 2016

Plaintiffs' operative complaint alleged that decedent George Fenimore, Jr., suffered from Alzheimer's disease and dementia, was prone to wandering away from home, and had begun to suffer an increased number of falls, leading his family to admit him to a local hospital. He was transferred from that hospital to Resnick Neuropsychiatric Hospital at UCLA (the Hospital). Within minutes of entering the Hospital, Fenimore was left unattended, and he fell and broke his hip. The Hospital initially attempted to conceal his fall, but eventually informed the family. Fenimore died in July 2013, while recovering from hip surgery. His family sued the Hospital for elder abuse, negligence, negligent hiring and supervision, and wrongful death. The trial court sustained the Hospital's demurrer without leave to amend as to the causes of action for elder abuse and negligent hiring and supervision, and plaintiffs dismissed their remaining causes of action (to permit an immediate appeal).

The Court of Appeal reversed, holding that the trial court improperly

sustained the demurrer as to the elder abuse cause of action. The Elder Abuse and Dependent Adult Civil Protection Act (Welf. & Inst. Code, § 15600 et seq.) does not provide liability for simple or gross negligence by health care providers. Rather, it requires plaintiffs to plead and prove something more than negligence—reckless, oppressive, fraudulent, or malicious conduct. Here, plaintiffs alleged the Hospital committed neglect by allowing Fenimore to fall minutes after entering the facility, failing to treat his fractured hip for four days, and violating certain state regulations for acute psychiatric hospitals, including staffing regulations. The Court of Appeal found that the first two allegations were insufficient to support elder abuse liability because they demonstrated no more than "mere incompetence or unskillfulness, i.e., negligence." However, plaintiffs' additional allegation that the Hospital violated state staffing regulations provided a sufficient basis for finding neglect. The Court of Appeal further held that allegations that the Hospital had "a knowing pattern and practice of understaffing in violation of applicable regulations" supported an inference of recklessness (defeating a demurrer), and were also a basis for distinguishing Worsham v. O'Connor Hospital (2014) 226 Cal.App.4th 331, 338. Accordingly, because plaintiffs stated at least one viable theory of elder abuse based on recklessness, the trial court should have overruled the Hospital's demurrer to that cause of action.

REVIEW GRANTED TO DECIDE WHETHER UTILIZATION REVIEW PHYSICIAN OWES THE INJURED WORKER A DUTY OF CARE AND MAY BE LIABLE FOR CAUSING A NEW INJURY OR AGGRAVATING AN EXISTING INJURY

King v. CompPartners, Inc. (2016) 243 Cal.App.4th 685, review granted April 13, 2016 (S232197)

The California Supreme Court granted review in King v. CompPartners, Inc. The Court of Appeal's decision was included in the written materials and was discussed at the Annual Meeting. The CSHA bulletin describing the Court of Appeal's now-unpublished decision is reproduced below for your reference:

Plaintiff Kirk King was prescribed the psychotropic medication Klonopin by his treating physician to treat anxiety and depression associated with his 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 then sued Dr. Sharma and CompPartners, Inc. (Dr. Sharma's employer) under various tort theories, alleging that he suffered seizures due to the immediate withdrawal of the Klonopin that Dr. Sharma's negligence caused. The trial court sustained the defendants' demurrer without leave to amend, ruling that King's claims were preempted by the Workers' Compensation Act (WCA) because they arose out of a utilization review decision, and that the defendants did not owe King any duty of care because Dr. Sharma was not King's treating physician and did not prescribe the Klonopin.

The Court of Appeal affirmed the sustaining of the demurrer, but reversed the denial of leave to amend. The court first addressed the preemption issue, explaining that injuries arising in the course of the workers' compensation claims process are preempted by the WCA because this process is " 'tethered to a compensable injury.' " However, if a new injury arises, or the prior workplace injury is aggravated, due to a mishap during the claims process, then preemption may not apply. The court interpreted King's complaint as alleging that his seizure arose either (1) from Dr. Sharma's incorrect determination that Klonopin was unnecessary, when in fact a reduced dosage was needed to wean Kirk off of the medication, or (2) from Dr. Sharma's failure to warn of the dangers of an abrupt withdrawal from Klonopin. The court held the first option was a challenge to Dr. Sharma's medical necessity determination, which is part of the claims process and therefore preempted. The second option, however, was not preempted because warning of the dangers of an abrupt withdrawal falls outside the medical necessity determination of the utilization review process. Therefore, because there was a possibility Kirk's tort causes of action were not preempted, the court held the trial court erred by denying leave to amend.

Finally, the court held that, under Palmer v. Superior Court (2002) 103 Cal. App.4th 953, there is a doctor-patient relationship between a utilization review doctor and the person whose medical records are being reviewed. While this meant Dr. Sharma owed Kirk a duty of care, it did not necessarily mean that Dr. Sharma was liable for Kirk's injury—the scope of duty depends upon the facts of the case. Kirk's complaint did not contain sufficient facts pertinent to the scope of the duty owed, so the Court of Appeal held that the trial court should have granted King leave to amend his complaint. The court concluded it was possible that Kirk could allege additional facts supporting a conclusion that, under the circumstances, Dr. Sharma owed a duty to warn about or protect King from the risk of seizures.

HOSPITAL'S SERVICES TO MEDICARE PATIENTS AFTER ITS ASSETS WERE PURCHASED COULD NOT BE BILLED UNTIL HOSPITAL WAS REACCREDITED AND ACQUIRED NEW PROVIDER AGREEMENT

Mission Hosp. Reg'l Med. Ctr. v. Burwell, ___ F.3d ___, No. 13-56264, 2016 WL 1399335 (9th Cir. Apr. 11, 2016)

Mission Hospital Regional Medical Center (a Medicare-approved acute care hospital) purchased South Coast Medical Center (also a Medicare-approved facility) in Laguna Beach. Mission attempted to avoid South Coast's potential liabilities under its Medicare provider agreement by purchasing only South Coast's assets. South Coast's liabilities included possible mandated reimbursements to Medicare for previous overpayments received by South Coast. As a consequence, the Secretary of Health and Human Services did not allow Mission to bill Medicare several million dollars for patient services at its new Laguna Beach campus before it acquired a Medicare provider agreement for that facility.

The Secretary's decision to disallow Mission's bills was upheld by an administrative law judge and by an agency appeals board. Mission sought judicial review, and the district court affirmed the agency decision.

The Ninth Circuit also affirmed. The court held that when Mission extinguished South Coast's Medicare provider agreement and refused to assume South Coast's contractual liability to return overpayments to Medicare, Mission did not and could not take assignment of South Coast's provider agreement. The Laguna Beach campus became, for Medicare purposes, a "new hospital" without a provider agreement. Moreover, the Laguna Beach campus could not enroll as a Medicare provider until it was separately accredited and entered into its own provider agreement. The court also rejected Mission's reliance on 42 C.F.R. § 489.13(d)(2), which states that the effective date of Medicare enrollment for a provider like Mission may be retroactive for up to one year from unpaid covered services provided to a Medicare beneficiary. The use of the word "may" in this regulation gives the Secretary discretion about when to grant retroactive coverage. The Secretary's policy was to exercise her discretion under this rule only in favor of accredited providers in compliance with the Medicare participation requirements. The court held that the Secretary reasonably determined that § 489.13(d)(2) was inapplicable here because there was no assurance that Mission's Laguna Beach campus was in compliance with the participation requirements at the time the services were provided.

PHYSICIAN DECLARED VEXATIOUS LITIGANT FOR FILING MERITLESS MOTIONS SEEKING RELIEF FROM UNAPPEALED JUDGMENT DENYING ADMINISTRATIVE MANDAMUS

Goodrich v. Sierra Vista Regional Medical Center (Apr. 27, 2016, B259724) ___ Cal.App.4th ___ [2016 WL 1702035]

Sierra Vista Regional Medical Center terminated Dr. Karen Goodrich's membership on its medical staff due to concerns about her fitness for practice. Dr. Goodrich requested an administrative hearing before a judicial review committee, but failed to appear at the hearing. Dr. Goodrich's attorney filed a petition for writ of administrative mandate seeking either reappointment to the medical staff or a new administrative hearing. The trial court denied the petition, and Dr. Goodrich failed to appeal.

After her attorney withdrew, Dr. Goodrich continued to litigate in propria persona. She filed five unsuccessful motions challenging the trial court's decision. Sierra Vista moved for an order declaring Dr. Goodrich a vexatious litigant under Code of Civil Procedure section 391. The trial court noted that only two of Dr. Goodrich's motions were filed after the time to appeal the judgment had expired, and refused declare her a vexatious litigant based on those filings. But the court stated its ruling was without prejudice to renewal if Dr. Goodrich continued to file meritless motions for relief. Less than a year later, Dr. Goodrich filed yet another motion attempting to relitigate the court's final judgment, and Sierra Vista again moved for an order declaring her a vexatious litigant. The court granted the motion, ordered Goodrich to post a $25,000 bond to proceed, and prohibited her from filing any new motions or litigation against Sierra Vista without prior leave of court. Dr. Goodrich appealed.

The Court of Appeal affirmed. The court rejected Dr. Goodrich's contention that section 391's reference to "repeatedly" attempting to relitigate the validity of the judgment required more than the three filings at issue here. The court explained there is no bright-line test, and the court looks to the underlying purposes of the statute—to prevent abuse of the court system by repeated relitigation. The court concluded that as few as three meritless motions may form the basis for a vexatious litigant designation where, as here, every motion seeks the same relief relating to the same judgment, and that relief has already been denied. The court also found substantial evidence that Dr. Goodrich had a "past pattern or practice" of attempting to relitigate the same issues against the same defendant, and this practice carried the risk of repetition. The court further noted that Goodrich failed to heed the trial court's admonition that further meritless motions addressing the same issues could subject her to a vexatious litigant finding.

MEDICARE-DEFRAUDING MEDICAL EQUIPMENT SUPPLIERS RECEIVED ENHANCED CRIMINAL SENTENCES BECAUSE THEY EXERCISED DISCRETION IN SELECTING PATIENTS' DEVICES

United States v. Adebimpe, ___ F.3d ___, No. 14-303, 2016 WL 1696866 (9th Cir. Apr. 28, 2016)

Patrick Sogbein and his wife, Adebola Adebimpe, owned separate medical equipment supply companies. Under Medicare, a physician may prescribe a mobility device and send an order to a supply company, which recommends specific equipment after assessing the patient's home. If the physician agrees with the recommendation, the patient receives the device and the supplier seeks reimbursement from Medicare. Sogbein and Adebimpe paid doctors to prescribe power wheelchairs without anyone assessing patients' need for them. A jury convicted them of conspiring to commit healthcare fraud and other charges. The district court imposed enhanced sentences under § 3B1.3 of the federal Sentencing Guidelines, which applies to defendants who abuse a position of "public or private trust," a phrase defined under the Guidelines as "professional or managerial discretion (i.e., substantial discretionary judgment that is ordinarily given considerable deference)." Sogbein and Adebimpe appealed their sentences, arguing that the abuse-of-trust enhancement was inapplicable.

A divided panel of the Ninth Circuit affirmed. The majority held that Sogbein and Adebimpe exercised managerial discretion because equipment suppliers must determine that equipment is medically appropriate for a patient, and that the equipment is compatible with the patient's home. Although a physician ultimately approves the equipment, the supplier must still justify the medical necessity for the equipment—a professional obligation separate from the physician's obligation. Defendants' Medicare submissions included a code certifying they had performed the requisite assessments. Sogbein also exercised discretion by instructing co-conspirators to assist him by prescribing power wheelchairs without regard for medical need. Finally, the majority held that defendants' submission of reimbursement claims through a third party, Noridian, did not remove the suppliers from a position of trust. The majority cautioned that the sentencing enhancement would not apply to those who merely report to Medicare, like ordinary taxpayers.

Judge Paez dissented, contending that a supplier's tasks are ministerial, not discretionary, because a doctor must order and ultimately approve a specific device. The dissent argued that a supplier simply verifies decisions made by a doctor, and that the certifying code input by suppliers is mandatory (not discretionary) to receive Medicare reimbursement. The dissent also questioned the majority's claim that Sogbein exercised discretion by asking physicians to write power wheelchair prescriptions, noting that this conduct should not enhance his sentence because it was simply the fraudulent conduct for which he was convicted.

LIMITATIONS PERIOD FOR PROFESSIONAL, NOT ORDINARY, NEGLIGENCE APPLIED TO INJURY RESULTING FROM EQUIPMENT USED TO IMPLEMENT DOCTOR'S ORDERS

Flores v. Presbyterian Intercommunity Hospital (2016) ___ Cal.4th ___, S209836, 2016 WL ___

Plaintiff Catherine Flores sued Presbyterian Intercommunity Hospital for premises liability and negligence, seeking damages for injuries she sustained (more than one year before filing suit) when a siderail on her hospital bed collapsed and she fell to the floor. The Hospital demurred, arguing that MICRA's one-year statute of limitations for professional negligence barred the action. (Code Civ. Proc., § 340.5.) The trial court sustained the Hospital's demurrer without leave to amend. Plaintiff appealed, arguing that the accident amounted to general (not professional) negligence, which is subject to a two-year statute of limitations. (Code Civ. Proc., § 335.1.) The Court of Appeal reversed, holding that the action sounded in general negligence because the bed rail did not collapse while the hospital was rendering professional services.

The California Supreme Court reversed the Court of Appeal and reinstated the trial court's order sustaining the demurrer. Each party had proposed a test for distinguishing ordinary from professional negligence based on prior case law, but the Supreme Court rejected the proposals. Instead, the Supreme Court focused on distinguishing the professional obligations of hospitals in rendering medical care to patients from their obligations (by virtue of operating public facilities) to maintain a safe premises for all users. The Court held that, "if the act or omission that led to the plaintiff's injuries was negligence in the maintenance of equipment that, under the prevailing standard of care, was reasonably required to treat or accommodate a physical or mental condition of the patient, the plaintiff's claim is one of professional negligence under section 340.5." (Slip op. 15.) Under this test, the Supreme Court indicated that the professional negligence statute of limitations would not apply if a person was injured when a chair collapsed in a hospital waiting room. But the Court held that the bed rail collapse in this case was different because a doctor had assessed Flores' condition and made a medical decision ordering the rails on her bed raised. Accordingly, the Court applied the professional negligence statute of limitations, which barred Flores' claim. The broad new test adopted by the Supreme Court can be seen as likely to expand MICRA's applicability.

FEDERAL LAW PREEMPTS CLAIM THAT MEDICAL DEVICE MANUFACTURER NEGLIGENTLY TRAINED PHYSICIANS

Glennen v. Allergan, Inc. (Apr. 29, 2016, A145367) ___ Cal.App.4th ___ [2016 WL 1732243]

Ashley Glennen sued Allergan, Inc., alleging that it negligently failed to train the surgeons who implanted Allergan's Lap-Band adjustable gastric banding in her body, resulting in numerous complications. The trial court sustained Allergan's demurrer without leave to amend, ruling that Glennen's claim was preempted by federal law.

The Court of Appeal affirmed on two grounds. First, it held that Glennen's "failure to adequately train physician" claim was expressly preempted by the Medical Device Amendments (MDA)

to the Food, Drug, and Cosmetics Act (FDCA). (See 21 U.S.C. § 301 et seq.). The MDA expressly preempts state law requirements that are different from or in addition to federal requirements. (21 U.S.C. § 360k(a).) Thus, if state law could impose liability notwithstanding compliance with federal requirements, then the state claim is preempted. Here, Glennen's negligence claim was based solely on her contention that Allergan provided inadequate training to the surgeon who installed her Lap-Band. However, because plaintiff did not dispute that Allergan provided the physician training required by the FDA's premarket approval process (PMA), and no other training was required by federal law, a state law verdict for Glennen would necessarily impose liability for something different than federal law requires. Thus, her negligence claim was expressly preempted.

The Court of Appeal also held that Glennen's claim was impliedly preempted by federal law. Implied preemption bars state law claims seeking to enforce the FDCA. The court observed that there is no state law duty requiring a medical device manufacturer to train physicians regarding the use of its devices, and Allergan did not voluntarily undertake to train physicians to use the Lap-Band. Rather, the FDA's PMA mandated certain physician training by Allergan as a condition of its approval for the Lap-Band. Therefore, but for the FDA's requirement that Allergan provide training to physicians implanting the device, Glennen would have no basis on which to allege the facts underlying her negligence claim. Thus, her claim did not "exist independently of the FDCA, and . . . [was] impliedly preempted."

In sum, the Court of Appeal's opinion teaches that there is a narrow gap through which state-law claims regarding medical devices must fit in order to escape federal preemption: the state claim must be premised on conduct that both (1) violates the FDCA (i.e., the state duty must perfectly parallel the federal duty), and (2) would give rise to recovery under state law even in the absence of the FDCA. Because Glennen's claim did not fit in this narrow gap, it was preempted.

U.S. SUPREME COURT REMANDS SUITS BY RELIGIOUS EMPLOYERS CHALLENGING ACA NOTICE REQUIREMENT ABOUT CONTRACEPTIVE INSURANCE COVERAGE

Zubik v. Burwell, ___ U.S. ___, 2016 WL 2842449 (May 16, 2016) (per curiam)

More than two dozen religious employers, in consolidated appeals arising from several circuit courts, had challenged the Affordable Care Act (ACA) requirement that they notify either their insurers or the Department of Health and Human Services of a religious objection to providing contraceptive coverage in order to be relieved of that obligation. These petitioners had argued that the notification requirement imposed a substantial burden on their religious beliefs and therefore violated the federal Religious Freedom Restoration Act (RFRA). The circuit courts had split on this issue, with most circuits holding that the notification requirement did not substantially burden religious beliefs.

The U.S. Supreme Court declined to resolve the issue. Following oral argument, the Court had inquired about a potential compromise in which petitioners would not give notice, but rather contract for a health plan that does not include coverage for contraception; in that event, the insurer and the government would arrange for cost-free contraceptive coverage for petitioners' employees. The parties filed supplemental briefs expressing theoretical approval of this compromise, while debating whether and how it could be implemented. Seizing on the parties' professed agreement that a compromise "is feasible," the Supreme Court vacated the lower court judgments and remanded for further proceedings and negotiations without deciding the issue presented. The Court expressed "no view on . . . whether petitioners' religious exercise has been substantially burdened, whether the Government has a compelling interest, or whether the current regulations are the least restrictive means of serving that interest."

Non-compliance with the ACA's notice requirement had exposed the religious employers to stiff penalties and taxes. The Court explained that the government may not extract those sums from petitioners because this litigation provided the government with adequate notice of petitioners' religious objectives. According to the Court, the government may now rely on this litigation-cum-notice to facilitate the provision of full contraceptive coverage to petitioners' employees. It remains to be seen whether this approach empowers the government to claim that these particular lawsuits are now moot (since petitioners sued to be relieved of the very obligation to provide notice that has now been satisfied in the eyes of the Court), or to contend that similar, future lawsuits by other parties likewise have a mooting effect because they satisfy the required notice of objection.

ELDER ABUSE NEGLECT CLAIM MAY NOT BE ASSERTED UNLESS THE DEFENDANT ASSUMED SIGNIFICANT RESPONSIBILITY FOR ATTENDING TO THE BASIC NEEDS OF AN ELDER OR DEPENDENT ADULT

Winn v. Pioneer Medical Group (May 19, 2016, S211793) __ Cal.4th __

Defendant physicians provided outpatient medical care to plaintiffs' mother, who suffered from vascular disease in her right leg. Though her condition worsened over a two-year period, the physicians never referred her to a vascular specialist. Ultimately, she developed gangrene, underwent amputations, and eventually died from complications. Plaintiffs then sued the decedent's treating physicians for elder abuse.

The trial court sustained defendants' demurrer, ruling that plaintiffs failed to adequately allege that the physicians denied their mother needed care in a reckless manner and that the professional negligence allegations cannot support an elder abuse action. The Court of Appeal reversed, holding that an elder abuse claim under Welfare & Institutions Code section 15657 does not require the defendant healthcare provider to have a custodial relationship with the patient, and that plaintiffs had sufficiently alleged reckless conduct such that the issue should be decided by a jury. The California Supreme Court granted review, and reversed the Court of Appeal's decision in a unanimous decision authored by Justice Cuellar.

The Supreme Court held that the Elder Abuse Act required the existence of a custodial relationship to establish a cause of action for neglect, and no custodial relationship was established by the defendants providing patients with medical treatment at an outpatient facility. First, the Supreme Court held that "a claim of neglect under the Elder Abuse Act requires a caretaking or custodial relationship — where a person has assumed significant responsibility for attending to one or more of those basic needs of the elder or dependent adult that an able-bodied and fully competent adult would ordinarily be capable of managing without assistance." The court explained that "it is the defendant's relationship with an elder or a dependent adult — not the defendant's professional standing or expertise [regarding whether a determination that medical care should be provided] — that makes the defendant potentially liable for neglect." Thus, "neglect requires a caretaking or custodial relationship that arises where an elder or dependent adult depends on another for the provision of some or all of his or her fundamental needs."

The Supreme Court rejected the plaintiff's argument that the Elder Abuse Act neglect standard applied whenever a physician provides medical treatment to an elderly patient at an outpatient facility — "[r]eading the act in such a manner would radically transform medical malpractice liability relative to the existing scheme." Accordingly, because the plaintiffs' complaint failed to include sufficient factual allegations showing that the decedent "relied on defendants in any way distinct from an able-bodied and fully competent adult's reliance on the advice and care of his or her medical providers" the complaint was insufficient to support an Elder Abuse cause of action based on the requisite "caretaking or custodial relationship" between the defendants and the decedent.

PROVIDERS CAN BE LIABLE ON FALSE CLAIMS ACT IMPLIED CERTIFICATION THEORY FOR SEEKING PAYMENT WHILE MATERIALLY MISREPRESENTING THEIR REGULATORY COMPLIANCE

Universal Health Services, Inc. v. United States ex rel. Escobar, 579 U.S. ___ [2016 WL 3317565] (June 16, 2016)

Yarushka Rivera, a minor, received mental health treatments subsidized by Medicaid at the Arbour clinic, a subsidiary of Universal Health Services. Rivers was diagnosed with bipolar disorder and prescribed a medicine that ultimately caused her death. After discovering that few of Arbour's employees were properly supervised or licensed, Rivera's parents filed a qui tam suit alleging that Universal Health violated the False Claims Act, 31 U.S.C. § 3729(a)(1)(A), which imposes penalties on those who "knowingly present" a "false or fraudulent claim for payment" to the federal government. The parents relied on the "implied certification" theory—under which a defendant implicitly certifies compliance with all regulations and other conditions of payment when it submits a claim—in alleging that Universal Health defrauded Medicaid by seeking reimbursement for its services despite violating licensing regulations. The district court dismissed the complaint because none of the regulations Arbour allegedly violated were conditions of payment. The First Circuit disagreed and reversed.

The Supreme Court granted certiorari to resolve a split in the circuit courts as to the availability and elements of the implied certification theory. The Court refused to adopt a bright-line rule. The Court unanimously held that providers can be liable under an implied certification theory if, in the course of requesting payments, they enter codes or make other specific representations about their goods or services that are deceptive in context (i.e., "misleading half-truths"). Drawing upon the common law of fraud, the Court explained that, when a claimant submits claim information and "omits its violations of statutory, regulatory, or contractual requirements, those omissions can be a basis for liability if they render the defendant's representations misleading." Although the Court endorsed the implied certification theory, its opinion clarifies that the theory will not apply in every instance when a provider has violated regulations—indeed, even the violation of an express condition of payment does not automatically trigger liability. The Court emphasized that "a misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government's payment decision in order to be actionable under the False Claims Act." (Emphasis added.) Thus, the doctrine of materiality limits the scope of liability under the implied certification theory, and the Court's opinion reiterates that the "materiality standard is demanding." Proof of materiality might include, for example, evidence that a provider knows the government refuses to pay claims when particular rules or regulations have not been followed. The Court remanded to allow the lower courts to reassess the parents' allegations under the new standard. Courts will now start building a body of case law regarding the circumstances that do (and do not) support implied certification liability.

COURT OF APPEAL REJECTS ENTERPRISE LIABILITY THEORY ASSERTED AGAINST A HEALTH INSURER BY A WRONGFUL DEATH PLAINTIFF SEEKING TO AVOID MICRA STATUTES

Gopal v. Kaiser Foundation Health Plan (B259808, May 26, 2016) ___ Cal.App.4th ___ [2016 WL 3125923], ordered published June 23, 2016

Siasmorn Gopal was admitted to the emergency room at Kaiser Foundation Hospitals (Hospital) and died after she was transferred to another hospital. Gopal's husband filed a wrongful death and negligence lawsuit against both hospitals, as well as Kaiser Foundation Health Plan (Plan). He alleged that Gopal was unlawfully treated differently than she would have been treated had she been a member of the Plan and that the different treatment caused her death.

Plaintiff joined the Plan as a defendant in an attempt to avoid application of the MICRA statutes. The trial court granted the Plan's motion for summary judgment. Plaintiff appealed, arguing the Plan was potentially liable under the "enterprise liability" theory for any breach of duty by the Hospital, or by the physician members of Southern California Permanente Medical Group (SCPMG) practicing there, because the operations of the Plan are closely intertwined with other Kaiser-related entities.

The Court of Appeal affirmed the trial court's rejection of the enterprise theory of liability. The appellate court explained that (1) the enterprise liability theory necessarily implicates the alter ego doctrine, (2) alter ego liability requires a unity of interests and ownership amounting to a merger of corporate personalities, (3) the Knox-Keene Act (Health & Saf. Code, § 1340 et seq.) authorizes a unity of interests and ownership among the Plan, the Hospital, SCPMG, and related entities, (4) alter ego liability is also contingent on an inequitable result, and (5) there is nothing inequitable about requiring victims of medical malpractice to seek compensation from their health care providers, rather than their health plans. "The fact that health care providers, and not health plans, are subject to MICRA is not an inequitable result, but a public policy determination made by the Legislature."

BUS. & PROF. CODE SECTION 2225 DOES NOT CREATE AN EXCEPTION TO THE PSYCHOTHERAPIST-PATIENT PRIVILEGE FOR MEDICAL BOARD INVESTIGATIONS

Gerner v. Super. Ct. of Los Angeles County (B268621, July 8, 2016) ___ Cal.App.4th___ [2016 WL 3676210]

T.O. filed a complaint with the California Medical Board regarding how his psychiatrist, Dr. Robert Gerner, was prescribing controlled substances to treat his ADHD. The Board initiated an investigation and interviewed T.O., who freely discussed the prescriptions written by Dr. Gerner, his statements to Dr. Gerner, and Dr. Gerner's responses. T.O later told an investigator that he was withdrawing his complaint against Dr. Gerner, and directed Dr. Gerner not to release his medical records to the Board. Nevertheless, at the investigator's request, the Board's physician-consultant reviewed the case, concluded that Dr. Gerner may have committed serious malpractice by prescribing large doses of controlled substances to T.O., and recommended a review of T.O.'s complete medical records. The Board's investigation unit issued an administrative subpoena commanding Dr. Gerner to produce those records, but he refused. The Board sought an order compelling compliance with that subpoena, but Dr. Gerner opposed the Board's motion, asserting the psychotherapist-patient privilege (Evid. Code, § 1014). The trial court ordered compliance, ruling that Business and Professions Code section 2225 (section 2225), an exception to the physician-patient privilege, created an exception to the psychotherapist-patient privilege because "all psychiatrists are physicians." Dr. Gerner petitioned for writ relief.

In a split decision, the Court of Appeal granted Dr. Gerner's writ petition and directed the trial court to vacate the order compelling compliance with the Board's subpoena. The majority held that neither section 2225 nor any other statute created an applicable exception to the psychotherapist-patient privilege under Evidence Code section 1014, and that no exception to this privilege could be judicially created. The court explained that the psychotherapist-patient privilege is liberally construed, and should not be equated with the physician-patient privilege. The majority further held that T.O. did not waive the privilege by disclosing medical information to the Board's investigator because those disclosures were conditioned on his right to withdraw his authorization for release of his medical information, and were not detailed or comprehensive enough to waive the confidentiality of his treatment record.

Justice Kriegler dissented on the ground that T.O.'s communications with the Board's investigator waived the psychotherapist-patient privilege with respect to his medical records reflecting Dr. Garner's prescribing practices.

REVOKING MEDICAL LICENSE IS INAPPROPRIATELY SEVERE DISCIPLINE FOR DEFRAUDING DISABILITY INSURER

Pirouzian v. Superior Court (B266015, June 29, 2016) __ Cal.App.4th ___ [2016 WL 3623622], ordered published July 11, 2016

After Dr. Amir Pirouzian took medical leave from his work as an pediatric ophthalmologist at a San Diego hospital due to a major depressive disorder, he claimed and received disability insurance benefits. He later accepted work at another hospital in Santa Clarita, but made false statements to his disability insurer about not working so he could continue receiving disability payments. He was eventually charged with felony insurance fraud, but pleaded guilty to a misdemeanor, which was later expunged after payment of restitution and probation. Years later, the Medical Board filed an accusation seeking to discipline Dr. Pirouzian. An ALJ determined that, although Dr. Pirouzian's dishonesty did not harm any patients, his medical license should be revoked to protect the public. The Board adopted the ALJ's decision, and the Superior Court denied a writ of administrative mandamus.

The Court of Appeal granted Dr. Pirouzian's petition for writ of mandate, holding that the Board's license revocation discipline was unduly harsh. The court explained that the Board's disciplinary authority must be aimed at protecting the public, while also rehabilitating physicians if possible. Accordingly, while Dr. Pirouzian's admitted dishonesty supported discipline, revoking his license was excessive and an abuse of discretion because it was not necessary to protect the public and because it did nothing to make Dr. Pirouzian a better physician. The court further explained that comments by the ALJ suggested the severe penalty was imposed to punish Dr. Pirouzian, due to the ALJ's determination that the negotiated criminal plea was too lenient. This was improper because Board discipline cannot be imposed for punitive reasons.