CASE SUMMARIES

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In an effort to continually provide value and serve as a central hub for the exchange of information, CSHA recently began distributing e-bulletins on the latest appellate decisions of significance to the healthcare industry. The e-bulletins, prepared by H. Thomas Watson and Peder K. Batalden of Horvitz & Levy, LLP, are sent periodically as legal decisions are rendered. The e-bulletins are not designed to contain an extensive analysis of the decisions and their implications, but rather a compilation of California healthcare-related decisions along with a brief narrative of the major issues presented and holdings reached. We are now printing these e-bulletins in the *CHLN*.

Harb v. City of Bakersfield (Jan. 23, 2015, F066839) ___ Cal.App.4th ___

While driving home from work, the plaintiff suffered a stroke and drove his car onto a sidewalk. The responding police officer did not call an ambulance immediately because she mistook plaintiff's vomiting, slurred speech and disorientation for intoxication and, after a struggle, placed him in handcuffs. The first ambulance to arrive left without plaintiff. Later, a second ambulance took him to a hospital where he received treatment and survived. The brain damage he suffered rendered him unable to care for himself.

Plaintiff and his wife sued the City of Bakersfield, the responding officer, the ambulance company and the paramedic who drove the first ambulance. They alleged the delay in providing medical treatment worsened the consequences of the stroke. A jury returned a defense verdict.

On appeal, plaintiff and his wife argued, among other things, that the jury should not have been instructed on comparative negligence because plaintiff's alleged negligent failure to manage his high blood pressure occurred before the accident and his interaction with the defendants. The Court of Appeal agreed, reversing the defense judgment and ordering a new trial. Addressing an issue of first impression, the Court of Appeal held that "where a plaintiff is seeking damages only for the aggravation or enhancement of an injury or condition, California will follow the majority view that a plaintiff's preaccident conduct cannot constitute comparative negligence when that conduct merely triggers the occasion for aid or medical attention. As a result, defendants who render aid or medical attention cannot reduce their liability for the harm resulting from their tortious acts and omissions by attributing fault to the plaintiff for causing the injury or condition in the first place."

Cal. Ins. Guarantee Ass'n v. Workers' Comp. Appeals Board (2014) 232 Cal. App.4th 543

When several surgical centers increased their fees for certain outpatient services provided to injured workers, CIGA and other employers' insurers disputed the increase and paid only the amounts they believed were appropriate for the services performed. The centers filed liens with the Workers' Compensation Appeals Board (WCAB) to collect the remaining balances. The parties litigated their billing dispute before a workers' compensation judge.

The administrative director of the Division of Workers' Compensation maintains an official medical fee schedule (OMFS) for the medical treatment of employees injured at work, but there was no established "reasonable maximum fees" for the procedures at issue during the relevant time period. Accordingly, the judge heard evidence about the percentage of facility fees the centers had collected for arthroscopic knee and shoulder procedures, and for certain epidural injections. The judge also received extensive and competing expert testimony about the usual and customary fees that centers of this type accepted as full payment for facility services. The judge ultimately settled on the appropriate fees using a formula that took into consideration what Medicare allowed, what the centers charged and accepted as payment, what the OMFS for hospitals allowed, and what other centers billed and accepted for the same or similar services.

The insurers sought review before the WCAB, which adopted and affirmed the judge's ruling. The insurers then petitioned for writ relief in the Court of Appeal. The court first held that recent statutory amendments (2012 Senate Bill No. 863) did not divest the WCAB of authority to rule on these medical billing disputes. Resolving an ambiguity in the new law, the court held that the independent bill review procedure established by Senate Bill 893 applied prospectively to new billing disputes, but not to billing disputes pending when the law was enacted. Accordingly, the WCAB had jurisdiction to resolve the billing dispute. On the merits, applying the multi-factor standard enunciated in *Tapia v. Skill Master Staffing* (2008) 73 Cal.Comp.Cases, the court held that the WCAB's resolution of the billing disputes was supported by substantial evidence. The Court of Appeal concluded that fees for arthroscopic knee procedures, arthroscopic shoulder procedures, and epidural injection procedures of $5,207.85, $4,340.95, and $2,337.52, respectively, were reasonable outpatient facility fees.

Blevin v. Coastal Surgical Institute (Jan. 12, 2015, B254787) ___ Cal.App.4th ___ [2015 WL 138218]

The Court of Appeal, addressing an issue of first impression, held that the one-year statute of limitations applicable in medical malpractice actions (Code Civ. Proc., §§ 340.5, 364) could be tolled by operation of Insurance Code section 11583.

The relevant facts in *Blevin* were undisputed. The plaintiff's knee became infected following surgery at the defendant's facility. The defendant paid plaintiff for the initial cost of treating the infection, but failed to inform plaintiff of the applicable statute of limitations governing medical malpractice claims. Plaintiff was not represented by counsel, and did not sign a release in exchange for the payment. When plaintiff filed suit 15 months later, the facility argued the suit was untimely under the one-year MICRA statute of limitations. The trial court ruled that the one-year limitations period was tolled by operation of Insurance Code section 11583, and later entered judgment on the jury's verdict in favor of the plaintiff.

The Court of Appeal affirmed, rejecting the defendant's arguments that the tolling provision of Insurance Code section 11583 should not apply to the MICRA statute of limitation. Section 11583 requires that any person making an advance payment as an accommodation to an injured person who is not represented by counsel must provide the recipient written notice of the applicable statute of limitations governing the causes of action that could be brought as a result of the injury. Section 11583 further states that the "[f]ailure to provide such written notice shall operate to toll any such applicable statute of limitations or time limitations from the time of such advance or partial payment until such written notice is actually given."

Relying by analogy on the Supreme Court's decision in *Belton v. Bowers Ambulance Service* (1999) 20 Cal.4th 928, 930, the Court of Appeal in *Blevin* held that Insurance Code section 11583 may toll the one-year MICRA limitations period, but not the maximum three-year limitations period applicable to medical malpractice actions.

Sarun v. Dignity Health (Dec. 15, 2014) ___ Cal.App.4th ___ [B251767, 2014 WL 7475221]

An uninsured patient signed an agreement to pay the "full charges" for emergency healthcare services provided by Northridge Hospital (a Dignity facility). The agreement explained that uninsured patients may qualify for government aid or financial assistance from Dignity.

Dignity later sent the patient an invoice for more than $23,000 that included an "uninsured discount." The invoice provided a phone number to call for assistance in determining eligibility for financial aid. Without seeking any other discounts or financial assistance, the patient filed an unfair-competition class action alleging that Dignity had violated the UCL and CLRA by failing to disclose that uninsured patients must pay more than other patients for the same services and by charging amounts that exceeded the reasonable value of the services.

Dignity demurred, arguing (among other points) that the patient had conceded he would be willing to pay $3,000, and that until he applied for financial assistance it was speculative whether he would ever need to pay more. The trial court agreed that the patient had not adequately alleged an "actual injury" and sustained the demurrer.

The Court of Appeal reversed. The court held that the patient had properly alleged an injury because, upon receipt of the invoice, the patient was either obliged to pay the full sum, or would be burdened with applying for financial assistance in an effort to eliminate that payment obligation. (Slip op. 10-11.) The argument advanced by Dignity would, according to the court, be akin to requiring a patient to mitigate his damages as a precondition to filing suit — a result at odds with analogous California Supreme Court precedent. The Court of Appeal remanded to allow the trial court to consider Dignity's other demurrer arguments in the first instance.

Rashidi v. Moser (Dec. 15, 2014, S214430)

After becoming blind in one eye following sinus surgery, plaintiff Hamid Rashidi sued his surgeon, Dr. Franklin Moser, the hospital, and the manufacturer of a medical device used during the procedure. Prior to trial, the hospital settled for $350,000 and the manufacturer settled for $2 million. At trial, no fault was apportioned to the hospital or the manufacturer. The jury awarded Rashidi $125,000 in economic damages, and $1,325,000 in noneconomic damages, which the trial court reduced to the $250,000 MICRA cap. (See Civ. Code, § 3333.2.) The Court of Appeal, perceiving a conflict between Civil Code sections 1431.2 (Proposition 51, which makes liability for noneconomic several rather than joint) and 3333.2 (the MICRA cap on noneconomic damages against healthcare providers), held that the capped award of $250,000 in noneconomic damage award should be offset based on the pretrial settlements because section 3333.2 was the controlling statute, and apportioned economic and noneconomic damage components of those settlements to arrive at an offset figure.

The Supreme Court reversed the Court of Appeal in a unanimous opinion. The Court held there was no conflict between the statutes because the MICRA cap applies only to noneconomic damages awarded in a judgment, not to the amount of money paid to settle a claim prior to trial. The Court further held that a defendant seeking to limit his liability for noneconomic damages must prove the liability of any settling codefendants, and secure the jury's apportionment of fault between all parties liable for the injury. Dr. Moser's failure to prove that any of the settling defendants were at fault meant that he alone was solely liable for the $250,000 in noneconomic damages awarded in the judgment. The Supreme Court refused to address the constitutionality of MICRA's damages cap, an issue on which Rashidi had sought review.

The Supreme Court has not yet acted on cases, such as *Hughes v. Pham*, where review was granted and briefing stayed pending the Supreme Court's decision in *Rashidi*. However, the Supreme Court often remands such cases to the Court of Appeal with instructions to reconsider their opinions in light of the decision in the lead case.

Hale v. Sharp Healthcare, D064023 — Court of Appeal, Fourth District, Division One — Nov. 19, 2014

Dagmar Hale received medical treatment from the emergency room at Sharp Grossmont Hospital. She was uninsured and signed an agreement obligating her to pay "in accordance with the regular rates and terms of the hospital." After receiving her bill — which included a substantial discount based on financial assistance — Hale filed a class action, alleging that Sharp charged her and other uninsured patients more for emergency services than it charged patients covered by private insurance or government plans.

The trial court initially certified a class, but subsequently granted Sharp's motion to decertify based on its showing that individualized inquiries were necessary to identify class members and to prove their entitlement to damages on a class-wide basis. The court ruled there was no reasonable means to ascertain the identities of class members without individualized inspections of more than 120,000 patient records, and that individualized issues regarding the right to recover damages predominated over common issues. The court denied Hale's application to amend the class definition. The Court of Appeal, Fourth District, Division One, affirmed, holding the trial court's decertification order was not an abuse of discretion.

Shaw v. Superior Court (THC-Orange County, Inc.), S221530—Review Granted—November 12, 2014

In this case, the California Supreme Court will decide whether there is a right to jury trial on a retaliation cause of action under Health and Safety Code section 1278.5.

An employee sued a health facility alleging that it retaliated against her by terminating her employment after she complained that the facility employed unlicensed, uncertified, and insufficiently trained health care professionals. She pleaded two causes of action: (1) wrongful termination in violation of public policy; and (2) violation of Health and Safety Code section 1278.5, which protects health care whistleblowers from their employers. The trial court ruled that the statutory cause of action was purely equitable and denied the employee's request for a jury trial, but then stayed the matter to allow her time to seek writ relief from that order.

In a published opinion, *Shaw v. Superior Court* (2014) 229 Cal.App.4th 12, the Court of Appeal, Second District, Division Three, granted the petition and reversed. The court concluded that, because Health and Safety Code section 1278.5 provided for "any remedy deemed warranted by the court pursuant to this chapter or any other applicable provision of statutory or common law," the Legislature contemplated that plaintiffs could pursue both equitable and legal remedies, and therefore were entitled to demand a jury trial.

On November 12, 2014, the Supreme Court granted review. Unless extensions of the briefing deadlines are granted (which is common, especially at the end of the year), the parties' briefing on the merits will conclude in early March 2015, and any amicus briefing should conclude by the end of April 2015. The Supreme Court will then schedule oral argument as soon as at least four justices agree to a tentative opinion, but there is no specific deadline governing when that might occur.