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## Voluntary Error Reporting

by Grant W. Peters, Esq.

One of the tenants of the quality improvement processes is that a careful analysis of errors will reveal how systems should be improved to reduce the incidences of those errors. The airline industry has long benefited from a careful analysis of each safety incident in an effort to determine what accidents could have been prevented by improved systems and procedures. Many have suggested that this same process should be applied to the health care industry. The problem has always been obtaining and safeguarding the data.

Various states have adopted voluntary reporting systems in an effort to enable collection and analysis of medical error data. After several years of consideration, congress has now enacted the Patient Safety & Quality Improvement Act of 2005 ("PSQIA"). As well as adding another acronym to the lexicon, PSQIA establishes a voluntary system of medical error reporting; one that actually provides a significant positive incentive for reporting.

PSQIA provides a broad privilege for "Patient Safety Work Product." Subject to certain exceptions, Patient Safety Work Product is privileged and is not subject to subpoena, court order or discovery in connection with federal, state, or local civil, criminal or administrative proceedings. The Federal Freedom of Information Act is not applicable to information gathered under the PSQIA. Patient Safety Work Product is defined as "any data, reports, records, memoranda, analysis...assembled or developed by a provider for reporting to a patient safety organization" and that are, in fact, "reported to a patient safety organization." Patient Safety Work Product thus excludes medical records, billing and discharge information, and similar information which is maintained, developed, or collected separately from a patient safety evaluation system.

In order for the provider to benefit from the privileges provided under PSQIA, the data must be assembled or developed for reporting *and* actually be reported to a patient safety organization. A patient safety organization is a newly defined private entity, whose primary activity is to "conduct activities that are to improve patient safety and the quality of health care delivery." It is envisioned that health care providers will contract with patient safety organizations to collect and process their patient safety information and provide analysis.

The reporting system established by PSQIA is an entirely voluntary one. Providers are not required to participate or report under the PSQIA. The clear evidentiary privileges for information assembled and reported to a patient safety organization could, however, provide a strong incentive for providers to voluntarily report.

It is hoped that greater availability and reliability of quality data will improve patient care. The privileges established under PSQIA will inevitably be challenged in court, and the result of those chal-

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## Grant W. Peters, M.D., J.D.



### Over 20 Years in Health Care Profession

Grant W. Peters, M.D., J.D. is a graduate of Loma Linda University where he received his degree in Chemistry and his M.D. He earned his juris doctorate at Boalt Hall School of Law, University of California, Berkeley. He also holds an M.S.A. in Healthcare Administration.

His legal practice at Borton Petrini LLP has been enhanced by his hands-on experience in the medical field. Grant has worked as an Associate Hospital Administrator for Professional Services; Chairman of the Department of Anesthesiology; Board of Directors/Governing Body Member; and President of a specialty physician group.

To stay abreast of the ever-changing legal field, Grant is a member of the Health Law Section of the American Bar Association and a Fellow of the American College of Legal Medicine.

Grant is available to provide legal services related to health care law.

## Appellate Decisions Affecting the Health Care Industry

by Dee H. Stasopolis, Esq.

In *Fitch v. Select Products Company* (2005), the California Supreme Court reviewed the propriety of a Medi-Cal lien. In *Fitch*, the decedent contracted cancer and received Medi-Cal benefits for his medical expenses. After his death, his survivors brought a wrongful death action, alleging that his cancer was caused by a third party's toxic product. The trial resulted in a judgment for the survivors. Medi-Cal asserted a lien on the judgment. It was granted by the trial court, and the Supreme Court reversed. The Supreme Court observed that the statutory language allowing for the assertion of a Medi-Cal lien against a judgment necessarily implied that lien recovery was permitted only when the damages recovered from the third party included the cost of medical treatment or other benefits provided by Medi-Cal. In this case, because the damages recoverable in the wrongful death action did not and could not include the decedent's medical expenses (that is a recovery pursued in a survivorship action), a lien could not be asserted against the survivors' recovery.

In *Kevin Conlan v. Sandra Shewry* (2005), the California State Department of Health Services sought review of an order from the superior court regarding a plan for compliance with a prior court order, which required the agency to ensure that respondents, A-class Medi-Cal beneficiaries, received reimbursement for covered medical expenses incurred during the three-month period before applying for assistance. The agency failed to implement the prior decision for nearly three years, and then sought review by the Appellate Court. While the court initially noted that the trial court's order was unappealable, and that the agency's brief did not contain a statement of appealability as required by the Rules of Court, because the delay had created extraordinary circumstances, the court chose to treat the appeal as a petition for extraordinary relief. The court admonished the agency's failure to implement the orders of the trial court, and found that the agency's claim of insufficient funding was incredible and not an excuse for failure to comply with the law. It denied the agency's appeal and ordered the agency to comply with the prior court order.

In *Viola v. California Department of Managed Health Care* (2005), the California Court of Appeal reviewed a complaint which sought declaratory and injunctive relief to prevent the California Department of Managed Health Care from approving health care service plans that included mandatory binding arbitration provisions. The trial court had previously dismissed the action and the plaintiffs

appealed. The Court of Appeal held there was no constitutional right to choose between arbitration and a jury trial in the context of a group plan negotiated by an employer and an insurer, and the legislature had the power to prescribe methods for waiver of the right to civil jury trial. Under the Knox-Keene Health Care Service Plan Act of 1975, the legislature had expressly approved arbitration as a form for resolution of disputes under health care service contracts, thus authorizing waiver of a jury trial. The court affirmed the trial court's prior determination dismissing plaintiffs' complaint.

In *Bhatt v. State Department of Health Services* (2005), the plaintiff/dentist appealed from a judgment of the superior court, which denied his petition for writ of administrative mandamus following an audit of his dental practice by the Department of Health Services for the State of California. The dentist contended that the administrative law judge erred in admitting into evidence Medi-Cal patients' claim detail reports (CDRs) under the official records exception to the hearsay rule. The court disagreed because Evid. Code § 1280 did not require the person making the entry to have personal knowledge of the transaction. Moreover, the CDRs satisfied the first requirement of the exception because under Evid. Code § 664, it was presumed that the official duties were regularly performed and the dentist offered no evidence to the contrary. The department's recording duties under the Welfare and Institutions Code were sufficiently specific to support the trial court's discretionary determination that a computer printout met the timeliness requirement of the official records exception to the hearsay rule. The dentist also failed to present evidence to establish that the CDRs were untrustworthy. The court held, taken together, Welfare and Institutions Code, along with other California code regulations, require that every provider of Medi-Cal services be enrolled in the Medi-Cal program in order to receive payment for such services. At the administrative hearing, the audit report found that there was inadequate or no documentation for certain billed services, and that some of the dentist's rendering services in appellant's office were not enrolled in the Denti-Cal program, as required, entitling Medi-Cal to recover payment for the services previously tendered.

In *Lifecare Centers of America v. Caloptima* (2005), the California Court of Appeal reviewed orders of the trial court, which denied a county-organized health system (COHS) request for judgment and granted the plaintiff health care provider's petition for peremptory writ of mandate requiring the COHS to make full payment on each of six treatment authorization requests (TARs), and awarded the provider attorneys' fees. The COHS had refused to pay the full amount requested because the provider failed to submit the TARs within 21 days of the patients' admissions. The Appellate Court held that the provider failed to prove that COHS' enforcement of its 21-day submission deadline was arbitrary, capricious, unsupported by substantial evidence or illegal. They further found that the provider presented no evidence demonstrating why the COHS should not apply the 21-day rule. The evidence submitted merely established that a clerical worker with "personal problems" failed to enter the required patient information into the computer in a timely fashion. The provider did not contend it could not meet the 21-day rule or that COHS had applied the rule in an arbitrary or capricious manner. Therefore, the Court of Appeal reversed the trial court's order issued in this matter.



### Dee H. Stasopolis

#### 20 Years Experience in Health Care Law



Dee H. Stasopolis is a Partner in the Bakersfield office of Borton Petrini LLP. Dee graduated from Southwestern School of Law in 1982. In addition to his admittance to the State Bar of California, he is admitted to practice before the U.S. Supreme Court, the Ninth Circuit Court of Appeals and all Federal District Courts for the State of California.

His areas of specialty at Borton Petrini LLP involve commercial health care litigation, health care law, and medical malpractice.

Dee is a member of the Kern County Bar Association, as well as the State Bar of California. His professional involvement also has included instructing insurance companies on settlement tactics, conducted legal-liability assessments for companies and has served as an arbitrator for the Los Angeles and Kern County Superior Courts. Dee has handled numerous cases involving medical malpractice, commercial health care disputes and other medical compliance issues. He is also a member of the DRI Section on Health Care Law.

#### Voluntary Error Reporting *continued from page 1*

lenges will determine the effectiveness of the reporting scheme. If the privileges prove to be as sound as they seem, and the information reported withstands the expected challenges, the voluntary reporting scheme may prove to be an extremely valuable tool in quality improvement for health care. It can be hoped the PSQIA will weather the storms and introduce a uniform system of reporting medical error data that can improve health care nationwide.



## Update On The Implementation of SB1950 by Dee H. Stasopolis

In 2002, SB1950 became the law. Its implementation is through the Medical Board of California, and the bill contained numerous provisions which affected the board's enforcement program and included the appointment of an enforcement monitor. The bill mandated two reports by the monitor, each evaluating the board's disciplinary system and procedures and making recommendations on how to improve its efficiency. The first of two reports were released on November 1, 2004. The monitor's initial report contained 55 recommendations for the board's enforcement program.

One major concern of the monitor was the time to complete an investigation. Business & Professions (B&P) Code section 2319 states the board shall set as its goal... "so that an average of no more than six months shall elapse from the receipt of a complaint to the completion of an investigation." B&P Code section 2225.5 allows specific times for the production of medical records from hospitals and physicians' offices, with civil penalties imposed for failure to comply. Therefore, a zero tolerance policy has been initiated by the board to obtain medical records in compliance with these sections. The new policy requires a physician to respond to a request for an interview within 72 hours, and to schedule the interview in the 15 days that follow the request. Failure to respond to the initial call or to appear at the scheduled appointment will result in the immediate issuance of a subpoena.

The board's medical experts are being closely monitored to ensure that they are meeting the required 30-day turnaround when reviewing cases. Complaints alleging improper physician conduct vary from sexual misconduct, criminal convictions and false advertising to the corporate unlicensed practice of medicine. The mission of the Medical Board of California is to protect health care consumers through the proper licensing and regulation of physicians and surgeons, and certain allied healthcare professionals, and through the vigorous, objective enforcement of the Medical Practice Act. The Medical Board publishes the results of its investigations on its websites. The following are a few of the recent notable results:

- *In re Robert Paul Iacono, M.D.* On September 12, 2005, the stipulated surrender of Dr. Iacono's medical license became effective. Dr. Iacono was accused of making dishonest and false statements on an application for hospital privileges and general unprofessional conduct in violation of Business & Professions Code sections 2234, 2234(e), and 2261. The Loma Linda University Medical Center suspended Iacono's staff privileges effective September 14, 1999, for 20 days, and also required him to complete anger management therapy after a third formal staff complaint regarding an incident in the operating room alleging abusive behavior and grabbing or hitting a technician's hand during a procedure. Iacono further subjected his license to discipline when, in December 2001, he responded "no" to a question on an application for privileges at Desert Regional Medical Center, in asking whether he had ever had his clinical privileges. . . "denied, suspended, restricted, reduced, subject to probationary conditions, revoked, or not renewed for possible incompetence, improper professional conduct or breach of conduct, or is any such action pending."

- *In re Joseph Edward O'Donnell, M.D.* On September 19, 2005, the stipulated surrender of Dr. O'Donnell's medical license became effective. The medical board had accused O'Donnell of violating Business & Professions Code sections 2234(b)(c)(d) [gross negligence, repeated negligent acts, incompetence] and 2266 [failure to maintain adequate and accurate medical records] in his care and treatment of two pregnant patients, resulting in the deaths of two infants shortly after delivery. It was alleged that O'Donnell had committed gross negligence, repeated negligent acts and/or incompetence during his care of both pregnant patients. As concerned the first patient, it was

alleged that he: "Failed to record the presentation, station and position of twin B during all of the maneuvers and manipulations intending to effect delivery; and failed to record the number and duration of pulls with the vacuum on twin B." With respect to the second patient, it was alleged O'Donnell: "Failed to provide the patient with adequate analgesia, failed to adequately document the fetal station at which the vacuum was applied to the baby, and failed to timely deliver the posterior arm of the baby." It was further alleged that during his care, treatment and management of the deliveries, O'Donnell failed to maintain adequate and accurate records.

- *In re John Robert Felkel, M.D.* This decision became effective August 8, 2005, and followed an accusation that was filed against Felkel, charging him with unprofessional conduct on the grounds that he had been convicted of a crime substantially related to the qualifications, functions or duties of a physician and surgeon. In particular, the accusation alleged that on or about October 2, 2005, Felkel's ex-girlfriend's two daughters reported that he had inappropriately touched them from 1998 to 2000. Felkel was subsequently arrested for investigation of continuous sexual abuse with a minor. Pornographic materials, photos and child erotica DVD movies were seized after a search was executed on his residence. On or about October 31, 2001, a felony complaint was filed in the Superior Court of California, County of San Bernardino, charging Felkel with 29 counts of violating Penal Code section 288(a)[lewd act upon a child under the age of 14]. Pursuant to Penal Code section 23, on or about November 7, 2001, a motion for an order suspending Felkel's medical license was granted. As a result of a plea bargain, on or about May 4, 2004, Felkel pled nolo contendere and was convicted of counts 1 and 29. He was sentenced to five years in state prison.

- *In re M. Ibrahim Kahn, M.D.* This decision became effective September 15, 2005. It results from a long history with Dr. Kahn, which first arose on April 29, 2005, after findings of gross negligence, repeated negligent acts, and failure to maintain adequate and accurate medical records in violation of Business & Professions Code sections 2234(b)(c) and 2266. On January 13, 2005, the board filed a petition to revoke his probation after he failed to comply with its terms, some of which include his failure to enroll in and complete a medical record-keeping course, failure to engage in an educational program course, failure to enroll in and complete an ethics course or to submit quarterly declarations stating whether compliance with all of the conditions of his probation had been met, and his failure to make cost recovery reimbursement payments to the board. After the medical board filed a petition to revoke probation, Kahn failed to file a notice of defense and he automatically waived his right to a hearing on the merits of the petition. His license was revoked by default.



### Legislative Update

by Dee H. Stasopolis, Esq.

As a result of the passage of SB231, the initial licensing fee and biannual renewal fee will increase from \$600 to \$790. Additionally, the reduced initial licensing fee will increase from \$300 to \$395. Every physician whose license expires on or after January 1, 2006, will be required to pay the new fee. Delinquency and penalty charges also will be increased and prepaying the fee prior to January 1, 2006, will not allow the physician to pay the old fee.



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