Arbitration Award

Instructions: Use of this form is optional. Within fifteen business days of the date of the closing of most arbitration hearings, the Neutral Arbitrator must serve the Arbitration Award on the Parties and the Independent Administrator. If there were three arbitrators, this Award must be signed by at least two of them. See Arbitration Rules 37 - 39. Return to:

Office of the Independent Administrator
3580 Wilshire Boulevard, Suite 2020
Los Angeles, California 90010
Fax: 213-637-8658

Arbitration Name: **Arbitration Number: 10349**

ADRIANA BURGER, the Arbitrator(s) selected to determine the dispute between the Parties in the above referenced action, find(s):

An arbitration hearing was held on Dec. 5, 6, + 7, 2011.

It is the decision of the Arbitrator(s) that the prevailing Party in this Arbitration is **Check one:**

______ The Claimant(s) is entitled to ______________________.

Or:

✓ The Respondent(s) is entitled to Judgment.

The reasons for this decision are attached.
(Arbitration Rule 38 requires that the Award provide findings of fact and conclusions of law, consistent with California Code of Civil Procedure Section 437c(g) or Section 632.)

Nothing in this arbitration decision prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this decision to the Department of Managed Health Care.

Adriana Burger
Signature of Neutral Arbitrator — Date: 1/2/2012

____
Signature of Party Arbitrator — Date

____
Signature of Party Arbitrator — Date

IN THE MATTER OF THE ARBITRATION BETWEEN

Claimant,

vs.

and

Respondents.

DECISION
FINDINGS OF FACT AND CONCLUSIONS OF LAW, [CCCP Section 632 and Arbitration Rule 38]

PARTIES AND COUNSEL:

Claimant and Counsel:
Claimant
Law Offices of
Esq.

( )

Respondents and Counsel:
et.al.

Esq.

( )

INTRODUCTION:

The Arbitration Hearing in this matter was heard on December 5, 6, & 7, 2011. After receipt of the parties' arbitration closing briefs on December 21, 2011, this matter was submitted and the hearing was closed. Exhibits marked Claimant's 1-25 and Respondents' 1-8 were admitted into evidence.

Witnesses called and sworn to testify:

Claimant:

M.D.
M.D.

Respondents:

M.D.
M.D.
Dr. M.D., by stipulation

Brief Summary of claim:

The Claimant is a 58-year-old male who underwent hernia repair surgery on August 21, 2009 at Harbor City Hospital. On August 27, 2009, the Claimant became critically ill and was rushed to the Hospital Emergency Room complaining of pain in his abdomen with serious symptoms. He was admitted into the hospital and received emergency surgery on August 28, 2009, due to sepsis resulting from a perforation of the small bowel. Claimant alleges that the surgery performed on August 21, 2009, at the Hospital by M.D. and his assistant resident M.D. ,caused the perforation of the small bowel. He alleges that in the process of the surgery Dr. placed a suture(s) into the wall of the small bowel that caused ischemia, a loss of blood flow, in the tissue of the bowel wall, which resulted in a 2-centimeter perforation in the small intestine. Since the emergency surgery of August 28, 2009, Claimant's wound has not completely healed and he will require additional surgery to repair the defect so that he can resume his normal activities. Claimant has endured a period of daily wound treatments, including a wound vacuum, until May 2010. In June 2010, he received a skin graft to repair the wound. However, the graft was rejected and failed to accomplish the desired healing. The Claimant is tentatively planning to have an abdominal wall reconstruction by both a general and plastic surgeon. Claimant seeks damages for loss of wages from August 21, 2009 of $55,493.10; for monies paid for co-pays and deductibles as a

consequence of the August 28th surgery totaling $6,557.90; and, for pain and suffering at the legal limit of $250,000.00.

ISSUES PRESENTED:

The issues presented in this arbitration are:

1) Whether Dr. placed a suture(s) in the small bowel.

2) If so, did the suture(s) cause ischemia resulting in the perforation of the small bowel?

3) Whether Dr. injured the small bowel resulting in the perforation of the small bowel? If so, did Dr. breach the standard of care?

4) Did Dr. fail to properly inspect the abdomen and fail to repair any damage to Claimant's bowel prior to closing the surgical site on August 21, 2009? Did he breach the standard of care?

FINDINGS OF FACTS:

1. ("Claimant") is a 58-year-old male with a history of abdominal surgeries, primarily hernia repairs: a splenectomy in 2003; hernia repair with mesh in 2005; and, hernia repair in 2007. He is HIV positive and diagnosed with acquired immunodeficiency syndrome. He is on active retroviral treatment. Claimant lives with his life partner Mr. Mr. is a sous chef and has lived with Claimant over 14 years. He is the primary support for Claimant. He is devoted, concerned, attentive, and helpful towards Claimant.

2. On August 6, 2010, Claimant met with Dr. M.D. ("Dr. ") for surgical consultation for repair of symptomatic umbilical hernia/incisional hernia due to prior open splenectomy and large lower midline scar. Claimant reported to Dr. that he was having intermittent tenderness and pain that was becoming increasingly painful.

On that same date Dr. and Claimant scheduled surgery for the incisional/ventral hernia repair with possible mesh.

3. On the same date Dr. discussed with Claimant the risks, benefits, and alternatives of surgery and informed consent was confirmed. Claimant was advised of possible complications, including the very unlikely adverse complication of bowel perforation. Claimant understood the risks and gave informed consent for the surgery. Dr. examined Claimant and noted that Claimant appeared to be in good condition, with additional conditions of HIV syndrome, lipodystrophy, and depression. Dr. found Claimant to be in stable condition. He cleared Claimant for surgery for August 21, 2010.

4. On August 21, 2010, Dr. and his Assisting Resident Surgeon, M.D. ("Dr. ") performed the incisional hernia repair, including insertion of the mesh. During the course of the surgery, Dr. and Dr. performed Lysis of Adhesions due to adhesions of small bowel and of old mesh up to the anterior abdominal wall. Claimant was found to have a small umbilical hernia and mild bowel adhesions to the mesh from the previous hernia surgery.

5. The Operative Note authored by Dr. and signed by Dr. dated August 21, 2009, *inter alia*, stated the following: The old scar, 5 cm superior and inferior to the umbilicus, was incised with a knife. Electrocautery was used to continue the dissection down to the hernia. There was a fascial defect from the prior surgeries. The sac was viewed and removed off the fascial defect. The sac and hernia contents were pushed back into the abdominal cavity. Small bowel adhesions to the abdominal wall were seen and lysed with the use of Metzenbaum scissors. Dr. reported that there were no

enterotomies or serosal tears. There was a small area of bleeding in the divided adhesions which was controlled with Fibrillar and stick ties. The small bowel was found to be patent open and free of strictures. A mesh was sutured in underlay fashion. The fascial defect was put back together and sutured into place. The Anesthesia Records states that the surgery commenced at 10:21 and ended at 12:05, lasting approximately 1 hour and 44 minutes.

6. Dr. testified to the above. consistent with the operating report. Dr. described that the adhesions were light in color and translucent, and that he was able to visualize what lay behind to avoid unintended damage during the operation. He explained that he made multiple inspections of the bowel, he irrigated the area and found no evidence of defects prior to the abdominal closure. Dr. testified that the Claimant had no signs of complications post-op. Dr. described that he sutured the omentum but that it is common to refer to adhesions as omentum adhesions. He did not feel the need to distinguish between the two types in his operating report. He used Metzenbaum scissors to avoid injury to the bowels. He described that his operating field was sufficient to visualize the area and bowels. He believed it was not medically indicated to enlarge the size of the surgical field. He did not recall observing old sutures on the bowels, in the surgical area. Dr. testified that had he seen old sutures in the operating site it would normally be his practice to note it in the surgical report. His assistant authored the operating report and Dr. did not note any errors in the report to correct. Dr. testified that Claimant had been progressing well after surgery and was discharged from the hospital when he believed Claimant was medically safe to do so.

7. There were no unusual events noted in either the operative report or anesthesia report.

8. On August 22, 2010, Dr. examined Claimant and noted that Claimant was doing well and could be discharged on the same day or on the 23rd, depending upon Claimant's pain. On August 22, 2010 at 11:36 A.M. Dr. responded to a report by the RN for possible tachycardia. The RN noted that the Claimant's pulse was in the 120s. Dr. noted that the Claimant was "asymptomatic" and determined that this was from coughing and ordered guaifensesin syrup. At 1918 (7:18 P.M.) the RN noted that Claimant's heartrate was 121 with a desat to 89%. She further noted that he was having problems taking deep breaths due to abdomen distention.

9. On August 23, 2010, Claimant was still hospitalized with a pulse of 118. Dr. examined Claimant and noted that Claimant would not be cleared until he had "better bowel function". On August 24, 2010, Dr. examined Claimant and noted that Claimant passed gas and felt better. Pulse was at 102. He also noted that the abdomen was not distended and had acceptable bowel sounds. Claimant was given an order for "advance diet" and it was predicted that he would be ready to go home the same day. On that same day, after instructions on care and diet, Claimant was discharged to go home and was reported to be without pain.

10. On August 27, 2009, Claimant became extremely ill. Mr. and Mr. described that Claimant was in pain and that his condition rapidly changed for the worse. Claimant was taken to the Hospital in Irvine, examined by M.D. who advised admission for likely sepsis syndrome with an acute abdomen. He was described as being critically ill. He was admitted to the

Anaheim Medical Center in Irvine for possible emergency exploratory surgery due to abdominal pain and sepsis. On that same date the Claimant was determined to be septic and required emergency surgery. There is no dispute that Claimant was in extreme danger and very ill.

11. On August 28, 2009, M.D. performed an emergency surgery on Claimant. Dr. identified and repaired a small bowel perforation that required resection and drainage of pelvic abscess. He noted that Claimant had edematous and friable bowel with bile peritonitis. There were marked fibrinous exudates at the right and lower abdomen, indicating that the area had been washed with bile for more than one day. The bowel was noted to have significant adhesions. Due to the condition of the bowel, Dr. removed a portion and reconnected the bowel. Dr. observed scattered sutures on the bowel in one area and the perforation with bile leakage. The sutures were on either sides of the perforation. Dr. forwarded the resected bowel to pathology. He closed the Claimant's abdomen with a Permacol mesh and maintained Claimant on a wound VAC.

12. Claimant was discharged from the hospital on September 10, 2009 to a skilled nursing facility due to his medical condition that required TPN (total parenteral nutrition), physical therapy and wound care with the wound VAC.

13. On June 22, 2010, Claimant received a skin graft in an effort to remedy the opened area from the inflamed surgical area. This turned out to be unsuccessful. Claimant is at present a candidate for plastic reconstruction but has not determined whether he wishes to endure another surgery. He presently has a fistulae protruding from the area and what appears to be a poorly healed surgical area. The parties stipulated that Dr. would testify that

1 there would be an 85% likelihood of success of repair with both general and plastic
2 surgery. Claimant would have to be hospitalized for approximately 1 week and would be
3 able to resume routine activities in approximately 6 weeks.
4
5 **Dr. M.D.:**
6
7 14. M.D., described that Claimant had a very complicated case due to the
8 large number of adhesions from prior abdominal surgeries. He opined that Dr. likely
9 failed to properly visualize the area, misidentified and misplaced sutures on or into the
10 small bowel rather than the intended adhesions. Dr. opined that the alleged
11 misplaced sutures caused ischemia that caused the perforation. He opined that this
12 conclusion was evidenced by the operating report, pathology report, and the proximity of
13 Claimant's life threatening symptoms developed two or three days after the alleged event
14 of improper suturing of the bowel. However, he also noted that the noted sutures,
15 described as granuloma, were more likely to have occurred from prior surgeries. Dr.
16
17 also testified that it would have been appropriate to place sutures in the
18 omentum, the fatty apron and that it would be clearly visualized by the black color of the
19 suture material.
20
21
22 15. Dr. also opined that if the perforation had been caused by a serosal tear it should
23 have been discovered had Dr. completed a through inspection. It was his opinion that
24 Dr. failed to perform a thorough inspection during surgery and thus fell below the
25 standard of care.
26
27
28

16. Dr. opined that circumstances of Claimant's prior surgical history required Dr. to do additional dissection out of caution, to make sure that an inspection of the small bowel was comprehensive. He opined that failure to do this was a breach and fell below acceptable standard of care.

17. Dr. opined that a perforation occurring and being missed is categorically below the standard of care and negligent. He based this upon his own experience, the operating report, and the pathology report. He found that the operating report on its face indicated that Dr. missed steps. He also opined that a fair reading of the operating report indicated that Dr. cut and sutured without proper visualization. He did not believe it was possible that Dr. actually visualized prior to cutting and suturing the area.

Dr. M.D.

18. In contrast to Dr. Dr. opined that Dr. operating report was the primary record of what occurred and that it concisely reported the procedures undertaken in the operation. Dr. opined that there was no evidence that Dr. had not visualized properly prior to cutting or suturing. He described that the report indicated that there were no enterotomies or serosal tears. Dr. opined that this notation indicated that Dr. properly inspected the bowels both visually and tactilely. He testified that his opinion was based on the circumstances Dr. experienced at the time of the surgery and what was reported in the operating report. Dr. did not agree with Dr. opinion that the circumstances at surgery necessitated further dissection due to possible complications. Dr. opined that perforations in the bowel are highly unusual and highly unlikely. He stated that a perforation within one

week of the procedure would not be *per se* evidence of negligence. He opined that sutures placed on the bowel should not normally cause a perforation or problems. Sutures are commonly placed intentionally on or in bowels without adverse consequences. If there had been a microscopic hole at the time of the surgery, it would not be reasonable for a surgeon to visualize the hole. He opined that usually small defects resolve without suturing. He described that the perforation could have resulted from an abrasion or other injury that was not visible at the time, including stricture or pulling. He opined that the actions of the surgeon had to be evaluated by what he or she actually saw at the time of surgery. Dr. opined that there was possibly a tear not visible to the surgeon's eye and that no reasonable surgeon under the same circumstances would have seen the tear. As such, he opined that Dr. surgical conduct and decisions did not fall below the standard of care.

Dr. M.D.:

19. Dr. performed the emergency surgery on the Claimant on August 28, 2009, 7 days after the first surgery. His testified that he observed less than 10 sutures in the area of the perforation. He observed sutures in the area of the perforation but none actually surrounding the perforation. There were also no sutures hanging on the perforation. He described that the sutures he observed were likely from the surgeries prior to August 21, 2009, and were appropriately placed. He opined that the condition of the sutures clearly indicated that they had been on the bowel for a significant period of time. He testified that it was his opinion that there was more likely than not a small defect on the bowel at the time of the August 21, 2009 surgery that enlarged after the abdomen was closed, possibly 2-3 days prior to discovery in the surgery. Dr. was emphatic that the

1 possible defect, if any at the time of the August 21st surgery, would have been too small
2 to be observed by any reasonable surgeon's examination. He was emphatic that the
3 sutures on the bowel were not causing any ischemia and were not sufficiently tight to
4 cause binding. The swelling and poor condition of the bowel noted in his operating report
5 were due to the products coming from the perforation in the bowel spilling into the
6 abdominal cavity. Dr. testified that he did not find that a suture caused the
7 perforation. He opined that it was more likely than not that the perforation was a result of
8 a defect occurring at the time of the August 21, 2009, surgery that was not large enough
9 to be seen by a reasonable surgeon operating under similar circumstances. He opined
10 that a microscopic perforation at the time of the surgery could progress to the 2 cm size
11 perforation in the 7-day period due to the conditions. He opined that Dr. surgical
12 conduct and decisions related to the surgery on August 21, 2009, did not fall below the
13 standard of care.
14
15
16
17 **CONCLUSIONS OF LAW**
18 20. The burden of proof is on the Claimant to establish that it is more likely than not that
19 Respondent failed to use the level of skill, knowledge and care that other reasonably
20 careful surgeons would use in similar circumstances based on the testimony of the expert
21 witnesses. A surgeon is not necessarily negligent if he makes an error that leads to
22 complications and adverse outcome. A surgeon is negligent only if he did not exercise the
23 skill, knowledge or care, as other reasonable surgeons would have in similar
24 circumstances. A surgeon is not necessarily negligent if there is an adverse result, no
25 matter how unusual, as long as he exercised the skill, knowledge and care as other
26 reasonable surgeons would have done in similar circumstances.
27
28

1 21. The expert testimony from all three experts established that it is not per se below the
2 standard of care for a defect or tear in the bowel to occur during abdominal surgery. It is
3 the failure to perform a reasonable inspection that would be below the standard of care.
4 22. The Claimant has suffered due to the unexpected adverse result. His life has been
5 significantly impacted as well as his immediate family members and life partner.
6
7 23. However, there is insufficient evidence to establish that Dr. placed a (any) suture(s) in
8 the small bowel. Dr. opined that there were no sutures at the site of the perforation at
9 the time he performed the surgery on the 28th. This was reinforced and supported by the
10 pathology report. Dr. opined that Dr. sutured the omentum and not the bowel.
11 Dr. opined that Dr. sutured the bowel, but he offered no evidence from the
12 record or pathology report to support his version of what he believed occurred at the
13 surgery. Dr. testimony was opined based upon his speculating that Dr.
14 committed an abbreviated surgery, which was not supported by any of the evidence.
15
16 24. There is insufficient evidence that Dr. placed sutures in the small bowel during the
17 surgery and caused perforation of the small bowel and therefore breached the standard of
18 care.
19 25. There is insufficient evidence that Dr. failed to discover defects that would cause the
20 perforation. Dr. acted with the skill, knowledge and experience that any other
21 reasonable surgeon would have acted under similar circumstances.
22
23 26. There is insufficient evidence that Dr. failed to properly inspect the abdomen and
24 repair any damage prior to closing the surgical site and therefore did not breach the
25 standard of care. Dr. testified that both he and Dr. examined the bowel prior
26 to closing and prior to and after lysing the area. Dr. also testified that sutures were not
27 applied to the bowels.
28

27. There is insufficient evidence to establish that a suture placed on the bowel would cause the perforation experienced by Claimant. All the medical expert witnesses testified that surgeons frequently place sutures on the bowels without adverse events unless sutures are done improperly. There was insufficient evidence that there were any sutures on the bowel other than sutures from the prior surgeries.

28. All expert witnesses testified that it would be highly unusual for a perforation to occur due to suturing the bowel unless the tissue was defective. It is also unusual to have a perforation of this magnitude occur postoperatively. However, the fact that a perforation occurred 5-7 days after the surgery on August 21, 2009, is insufficient to establish that Dr. failed to discover a correctable defect that would lead to the perforation.

29. It is the finding of the Arbitrator that there is insufficient evidence to establish Respondents' negligence in this matter. Judgment is for Respondents.

DATED: December 27, 2011 By:________________________

ADRIANA BURGER,
NEUTRAL ARBITRATOR

Arbitration Award

Instructions: The Neutral Arbitrator must serve the Award form on the parties and the within fifteen business days of the date of the closing of most arbitration hearings. (If there are three arbitrators, this Award must be signed by at least two of them.) See Rules 37 - 39.

Arbitration Name: **Arbitration Number:** 13166

The Arbitrator(s) selected to determine the dispute between the Parties in the above referenced action, find(s):

An arbitration hearing was held on July 5, 6, 2016.

It is the decision of the Arbitrator(s) that the prevailing Party in this Arbitration is **(check one)**:

[X] The Claimant(s) is entitled to $100.00 credit or $100.00 refund of Emergency room Co-pay of 2/20/2014.

Or:

[ ] The Respondent(s) is entitled to ________.

The hearing was conducted **(check one)**:
[X] in person [ ] by telephone [ ] video conference [ ] by documents only

Were attorney's fees awarded? [ ] yes [X] no
If yes, how much and to whom? ________

The reasons for this decision are attached.
(Rule 38 requires that the Award provide findings of fact and conclusions of law, consistent with California Code of Civil Procedure Section 437c(g) or Section 632.)

Nothing in this arbitration decision prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this decision to the Department of Managed Health Care.

Adrian Baz [signature] — 7/18/16
Signature of Neutral Arbitrator — Date

________ — ________
Signature of Party Arbitrator — Date

________ — ________
Signature of Party Arbitrator — Date

IN THE MATTER OF THE ARBITRATION BETWEEN

AND

Claimants,

vs.

AND

Respondents.

ARBITRATION CASE No. 13783
ORDER REGARDING RESPONDENTS' MOTION FOR SUMMARY JUDGMENT

This matter is before the Arbitrator on Respondents' Motion for Summary Judgment. The Arbitrator has read the moving and opposition papers. The parties were also afforded the opportunity to present oral arguments on November 14, 2016.

As explained below, the Arbitrator grants Respondents' Motion for Summary Judgment.

<u>Summary of the Case</u>

On April 6, 2009, Claimant, presented to the due to a traumatic injury requiring Emergency Room treatment. The parties are in agreement that was a member of Respondents' Health Plan and was covered for emergency care.

Claimant, received care at on April 6 and 7, 2009.

The treating facility, and are parties to a Health Care Services Agreement Contract which provides in part that must submit their bill for services to within 90 days of the date of incurring charges or 90 days from discharge.

Claimants contend that on June 25, 2009, Respondents communicated to that was no longer covered under the health plan and that coverage had been terminated on March 31, 2009. Subsequently made collection attempts against Claimants.

According to Claimant, on July 19, 2010, submitted their bill to for services provided to According to Respondents, on September 30, 2010, submitted their bill for services provided to Either and both claims would have been considered untimely according to the Agreement.

After receipt of the bill, Respondents wrote to the and informed them that the bill had been denied because the bill had been submitted to Respondents outside the time restrictions of their agreement.

On September 30, 2010, Respondents sent a letter to Claimants. In this letter Respondents notified Claimants that bill had been denied due to the bill having been submitted untimely. The letter provided information on how to dispute the determination and the Claimants' appeal rights.

A fair reading of the denial determination clearly is that bill was considered untimely, but never the less a covered claim. This distinction is important because under the terms of the contract for coverage and the terms of the letter dated September 30, 2010, Claimants had the right to appeal the denial of payment for the services, arguably permitting Respondents and to attempt to resolve the bill. Unfortunately, this was apparently not clear to Claimants.

Claimants contend that they contacted Respondents in July 2010 and were promised that the bill would be paid

On March 13, 2013, the filed a lawsuit against Claimants which was served on June 22, 2013.

On September 5, 2013, the filed a Request for Entry of Default and Court Judgment against the Claimants. Claimants did not file a response to the lawsuit.

On September 17, 2013, the Default Judgment was entered against Claimants.

Judgment was entered against Claimants in the amount of $7,316.92, in damages, and a total of $3,072.98 in interest, attorney fees, and court costs.

Following the Default Judgment, Claimants incurred negative commercial consequences which caused them harm

In September 2013 through November 5, 2013, Claimants contacted Respondents and told Respondents that a lawsuit and default judgment had been filed. Respondents told Claimants to file an appeal, which claimants did.

On September 18, 2013, Claimants filed a grievance with the Department of Managed Health Care, ("DMHC") which oversees Health Maintenance Organizations. In their grievance, Claimant sought the $3,072.98.

In a letter dated June 15, 2015, the DMHC denied the request "in accordance with the terms and conditions in our Evidence of Coverage (health plan contract). Please be advised that there is no provision in your health plan contract that allows for coverage for court and interest fees."

On November 14, 2016, the Arbitrator sustained Respondents' objections to Claimants' submission of undisputed facts because each assertion was improperly pled and the Claimants' facts were without proper foundation. Nevertheless, Claimants' timeline of events are consistent with the parties' moving and opposition submissions with regards to the Respondents' Motion for Summary Judgment.

Discussion

The issue presented in the Motion for Summary Judgment is whether there are any triable issues of material facts which would entitle a judgment in favor, as a matter of law, pursuant to Code of Civil Procedure section 437c. Claimants have alleged that Respondents acted in bad faith by denying coverage to In this matter, claimants prays for recovery of losses which claimants incurred as a result of a default judgment that was taken against claimants.

The issue in this matter is whether or not Respondents are responsible for the consequential damages resulting in the lawsuit and default judgment against claimants.

As a matter of law, the basis of Claimants' claim is controlled by the agreement between the Claimants and Respondents. The terms of the contract only cover actual emergency care services. Based upon the contract, and as a matter of law, Respondents are not responsible under the contract for the damages that followed from failure to timely submit the bill to Respondents.

As a matter of equity, the Claimants have asserted that Respondents are liable for all the consequential damages for "causing" to sue Claimants. Had Claimants appealed the initial rejection of the bill, in a timely fashion, the

Claimants would be in a much stronger position to recover their damages as a matter of equity. However, the facts, as stated by both parties preclude this recovery. The applicable principle is commonly known as "laches". The definition of laches is that there is an unreasonable delay in making an assertion or claim, such as asserting a right, or making an application for redress, which may result in refusal. Claimants assert that they were misled in 2010 that Respondents would pay the bill. However, the Claimants failed to produce any admissible evidence in their opposition, to prove that the delay was reasonable under the circumstances. Additionally, under equitable recovery, the principle that a claimant must make reasonable efforts to mitigate damages is well entrenched in the laws of contracts and torts. The duty to mitigate damages operates to reduce damages to the extent losses could have been avoided had the Claimants, post alleged breach, acted reasonably under the circumstances. In this matter, Claimants failed to respond to Respondents' notice of Appeal and collections efforts. Claimants failed to address this issue in any of their oppositions to the Motion for Summary Judgment.

This is an unfortunate situation as it appears that failed to properly submit their bill for services according to the Agreement between and Respondents which required submission with 90 days that the charges were incurred. It was incumbent on Claimants to swiftly and without delay to appeal under the terms of their contract. By taking little or no action until 2013, Claimants' claim under an equity theory fails and is therefore an issue that would entitle Respondents a judgment in their favor.

With regards to violations of Insurance Code provisions, Respondents have correctly pointed out that Respondents are an HMO and the Insurance Code provisions are inapplicable to the facts in this matter. The sections cited by Claimants and the corresponding case law are not on point with regards to this issue.

The rules regarding Emergency Room "balance billing", which is prohibited in California, does not apply to Respondents, but would appear to be applicable against for pursuing the balance against a party who was covered under the HMO. was prohibited from attempting to collect or file suit for the balance from Claimants, a practice known as balance billing. placed Claimants in the middle, which violated their obligation under a case entitled *Prospect v. Northridge* (2009) 45 Cal. 4th 497,507. In that case the court stated that if a health care service plan does not pay the full billed charges for emergency services, the providers of the emergency services may not seek to collect the balance from the patient, but must instead dispute the payment with the health plan. There is no case law cited by either party or that the Arbitrator could find,

which shifts responsibility to Respondents for
violation of this established principle.
practice of billing and filing suit against Claimants also violates California Code of Regulations, title 28, section 1300.7139(a) which prohibits a provider of Emergency Room services from billing or attempting to collect amounts owed to the provider.

Conclusion

Based upon the oral arguments, motions and oppositions filed by the parties, there are no triable issues of material fact which would entitle a judgment in favor of Claimants, as a matter of law. Accordingly, the Motion for Summary Judgment is granted.

Nothing in this arbitration decision prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this decision to the Department of Managed Health Care.

November 18, 2016

Adriana M. Burger
Arbitrator