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 . If there were three arbitrators, this Award must be signed by at least two of them. See Arbitration Rules 37 - 39. Return to:

Fax:

Arbitration Name: **(2nd)** **Arbitration Number:** **12545**

Jon A. Hammerbeck, the Arbitrator(s) selected to determine the dispute between the Parties in the above referenced action, find(s):

An arbitration hearing was held on November 2-6, 2015.

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

_____ The Claimant(s) is entitled to nothing,.

Or:

__x__ The Respondent(s) is entitled to costs.

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.

Signature of Neutral Arbitrator	12-1-15 Date
Signature of Party Arbitrator	Date
Signature of Party Arbitrator	Date

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Arbitrator

IN THE MATTER OF THE ARBITRATION BETWEEN

, Claimant, vs. , , ; and DOES 1 through 100, inclusive, Respondents.	Case No.: **AWARD OF ARBITRATOR** Hearing Date: February 1, 2015 Time: 10:00 a.m. Place: Telephonic Arbitration Demand: October 16, 2013 Arbitration Date: March 30, 2015

STANDARD OF CARE

Respondent as an organization, as well as each of its medical providers at issue here (Drs. and) owe a separate duty to claimant to not breach the standard of care.

While the March 27, 2009 "pre-surgery" standard of care of respondent and its various providers met the standard of care (per testimony of respondents' experts and), the "post-surgery" standard of care must be assessed separately.

As was the testimony of both claimant and respondent experts, there was a team of a multi-disciplinary basis that was responsible for providing sufficient care to the patient regarding the prostrate cancer and the mass. Because both the prostate and a tumor were both receiving care and treatment, respondent had both Drs. and assessing the different and separate conditions per their specialties (for the prostate and for the tumor). Both doctors anticipated and scheduled post-surgery follow-up appointments with the patient. (Claimant's Exhibits 2 through 6.)

The record as contained in the exhibits, including Claimant's Exhibits 2 through 6, seem to contain sufficient evidence that would establish that the patient and the family, through the authorized representative, , received explanation of both the prostate cancer and tumor status and anticipated follow-up care. (Claimant's Exhibits 2 through 7, deposition of experts of both claimant and respondent.)

Dr. 's notes after the February 26, 2009 appointment showed a coded diagnosis that included one for sarcoma – low grade, 171.9 k CA (claimant's Exhibit 2). It is significant to note that this diagnosis and coding was not carried through in subsequent respondents' documentation regarding the various care provided to the patient (as acknowledged by respondents' expert). Over time typically this would be done. This then raises the question that had this been done, would the patient have received different follow-up care from one or more of the various individual care providers with respondent.

While Dr. in his testimony took great pains to state that he was only treating the prostate condition post-surgery, he acknowledged that he was also providing accommodation-oriented care and supervision for the patient as he scheduled a variety of CT scans in May, July and November of 2009 (he made the decision after the May, 2009 CT scan to not foward it to Dr.). Per the testimony of Dr. for claimant, this established him as the care provider for the patient regarding the tumor as well as the prostate. Dr. in essence became the "captain of the ship" and then became responsible for breaches of the standard of care for others under his responsibility. *See Fields v. Yusef* (2006) 145 Cal.App.4th 1381.

Because it is clear that the patient did not receive the two to three-year CT scan follow-up care every six months that even Dr. indicated would have been appropriate (had she reviewed the post-surgery pathology report), Dr. in his status as "captain of the ship" breached the standard of care for failure to make sure that the oncology specialist Dr. had post-surgery contact and supervision of the patient's tumor.

Failure to keep a closer check on a patient after surgery does result in sufficient breach of standard of care evidence. See *Stephenson v. Kaiser* (1962) 203 Cal.App.2d 631, 636-637 (Treating surgeon told plaintiff to "feel free to come back in" if there were problems. The doctor did not advise

her to come back. A closer check on the patient should have been performed.) Here, Dr. , at a minimum, as "captain of the ship" should have done more to keep a closer check on the patient.

Regarding the referral to Dr. , a physician's failure to follow up on a referral is also a breach of the standard of care. See *Clark v. Laughlin* (1977) 68 Cal.App.3d 506, 513. Here, Dr. should have done more to make sure the patient did follow up with Dr. after the March 27, 2009 surgery.

Regarding Dr. 's staff's missed and cancelled appointment conduct, the testimony established that at most there was a single call placed presumably to, although unclear, the phone number of the patient. It is significant there is no evidence in the record nor any testimony that Dr. 's staff ever made an effort to call , who had been established under protocol as a representative of the patient.

No letter was sent which should have been done per Dr. 's testimony. Thus Dr. also breached the standard of care for her staff's failure to adequately follow up with the patient for both the missed appointment and canceled appointments in April and May of 2009 under the "captain of the ship" doctrine. *See Fields v. Yusef.*

It was clear in the medical documentation, such as claimant's Exhibits 2 through 7, that was actively involved with following up and asking questions regarding her father's care and treatment both before and after the March 27, 2009 surgery. Respondents' various medical providers and their staff's failure to further follow up with her after the canceled appointment and then missed appointment is a breach of the standard of care. There is no evidence provided by respondents that such efforts to contact was ever made or documented.

While the pathology report post-surgery was the subject of contradictory testimony from claimant and respondents' experts regarding the significance of the "positive margin" comments, based on Dr. 's own testimony, it appears that she would have wanted follow-up care in the form of CT scans every six months for the next two years at a minimum, and potentially three years. This was not done and this is a breach of the standard of care.

CAUSATION

For claimant to prevail in this matter, it must not only establish by a preponderance of the evidence and to a reasonable medical certainty that the standard of care was breached by respondent, which has been done, claimant must also prove that this breach in fact caused damages alleged by claimant, which was the premature passing of the patient and the consequent various economic and non-economic damages as set forth in testimony.

The testimony of the two oncologists, Dr. and Dr. , are completely at odds with each other as to whether the failure to provide six-month CT scans for a two or three-year period after March, 2009 would have made any difference as to the ultimate demise of the patient. Dr. testified that the mass would have been detectable sometime in 2010 and the cancer's metastasis would have started in 2011. Presumably, therefore had the CT scans been done per Dr. , this would have been visible on the CT scan and a surgery could have been done at some point in either 2010 or 2011.

Even if true, there is no persuasive indication in the evidence by a preponderance that this would have had any impact on extending the patient's life span (or how much longer) through theorized surgery or other treatment, as to someone who would have been approximately 78 at that time. Claimant must meet this burden regarding the causation element.

Dr. 's testimony is based on her review of certain of the records and her experience in the field. Dr. 's opinions were also based on his review of records and his experience in the oncology field. What Dr. also indicated, however, was that in his view, the only objective evidence in this matter, i.e. the size and extent of the tumors and metastasis in June of 2012, and the later significant growth as noted in August and later CT scans, established the highly aggressive and quick-growing nature of the various tumors. Dr. provided testimony, which was not contradicted by any objectively based foundation for any opinion of Dr. , that given that cancers grow more quickly at first, that therefore the metastasizing extent of the cancer, and the potentially treatable condition of the cancer, would not have been possible much sooner than June of 2012.

Thus, Dr. testified that there would not have been a point where had the CT scans been done every six months for either a two or three-year period that any earlier treatable stage of the

disease could have been accomplished for the patient, thus extending his life. Dr. stated that the cancer would have spread before being detectable, and there was at most a very brief window of detectability. Claimant has not met its burden here to a reasonable medical certainty.

All expert witnesses in this matter have testified as to the extremely rare nature of this tumor. It is certainly possible that the tumor may have been detectable at some point in 2010 or 2011. This in itself does not establish causation. Further, there is no objective evidence of this, including tumor origin, size, and location, and Dr. 's testimony is based only on certain records and her experience.

When there are completely competing and contradictory testimony from the claimant and respondents' experts as to causation, based on experience and document review, there needs to be something additional for claimant to then meet the burden to establish the causation element. There is nothing in Dr. 's testimony, or any other testimony or evidence provided by claimant that does this. In fact, as per Dr. , the only objective data is the objective data found in the CT scans starting on June 12, and then Dr. 's expert opinion as to the likelihood or probabilities of when such a growth and subsequent metastasis would have been detectable on the CT scans. Dr. provides no such similar testimony.

Thus, the causation element has not been established by claimant and the ruling thus must be in favor of the respondents, with claimant recovering nothing.

Dated: December 1, 2015

FORD, WALKER, HAGGERTY & BEHAR

BY: ______________________
JON A. HAMMERBECK, ESQ.
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Arbitrator

IN THE MATTER OF THE ARBITRATION BETWEEN

Ph.D., et al.

Claimant,

vs.

et al.

Respondent.

No.: 13737

NOTICE OF RULING RE: RESPONDENT MOTION FOR SUMMARY JUDGMENT OR IN THE ALTERNATIVE SUMMARY ADJUDICATION, AGAINST CLAIMANT ESTATE OF

Arbitration Demand: September 1, 2015
Arbitration Date: April 24-26, 2017

TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

Respondent brought a Motion for Summary Judgment, or in the alternative Summary Adjudication, against Claimant, Estate of ("Estate") that was heard on March 24, 2017. The telephonic hearing was attended by Claimant, on behalf of the Estate of and counsel for Respondent and moving party. The subject motion was directed against the Claimant, Estate of There had been a prior Motion for Summary Judgment that was granted, brought by Respondent, against Claimant, on December 22, 2016. Thus the only remaining claimant in this matter is the Estate of

The remaining claims brought by the Estate are for alleged improper (negligent or intentional) dis-enrollment, or re-enrollment, of decedent, in the The

claim sets forth generally that was disenrolled by Respondent in or about March 8, 2011, and then re-enrolled, on April 1, 2014, which had the effect of terminating coverage decedent had under Medicare/

With regard to the alleged disenrollment claims, Respondent argues that the alleged disenrollment would have occurred in or about March 8, 2011. Given that notice of claim was submitted on September 1, 2015, Respondent argues the statute of limitations would bar such a claim CCP 335.1. The arbitrator finds that there are no triable issues of fact remaining as to this component of the Estate's claim regarding disenrollment, and thus, claimant has no claim of any merit regarding disenrollment claims. This claim was not preserved within the cited statute of limitations period and is thus barred.

With regard to the allegations regarding negligent or intentional re-enrollment, there is no issue regarding the statute of limitations. Respondent argues in its papers that decent was mentally competent and thus had the capacity to knowingly enter into an agreement to reenroll into the Moving party provides evidence in the form of a declaration from Dr. on this point. It also submits evidence in the form of the recorded telephone conversation and other documents (Respondent Exhibit F, Respondent Summary of Undisputed Facts 9-17) between decedent and regarding his re-enrollment.

Claimant opposes through a late served opposition, that was served on March 19, 2017 for the originally scheduled hearing to take place on March 20, 2017. Due to telephone conference issues, the telephonic hearing was continued to March 24, 2017. This arbitrator does have the discretion to exclude the late served opposition on the grounds that it was not timely under Code of Civil Procedure §427(c). The arbitrator also has the discretion to consider such opposition. In this case, in this situation, this arbitrator does exercise its discretion to consider such opposition.

The opposition also is lacking in terms of required format, including a separate statement of response to the statement of material and undisputed facts submitted by Respondent. Found within the opposition submitted by Claimant, there are a bare modicum of sufficient statements and evidence that within the broadest possible discretion permitted by under law for the arbitrator, it could be construed as containing statements in opposition to some of the statements of indisputable material fact submitted

by Respondent.

In particular, Claimant opposes the motion on the grounds that Mr. was not mentally competent to knowingly and with comprehension understand the re-enrollment process and to understand the implications of said re-enrollment, which included the cessation of the coverage. It is Claimant's position that decedent was undergoing a variety of health care treatment at the time, including both physician and skilled nursing care, which was no longer covered under the coverage of April 1, 2016 when the care coverage started. (In fact it appears that continued to get provided care, Respondent Fact 22). While Respondent disputes the Claimant's version of the facts regarding the mental competence of again interpreting the Claimant's evidence contained in its Opposition as broadly as permitted under law, because the issue goes to the mental state and understanding of it can be seen that there is a triable issue of fact as to whether he did understand and knowingly engage in the re-enrollment process. Given this triable issue of fact as to his mental state, there would at least be a triable issue of fact as to whether there was a duty under the negligent re-enrollment claim, or a breach of the duty, or any intentional act regarding re-enrollment itself.

California Civil Code §3428 permits plan members to sue directly healthcare plans such as Respondent. Such theories can include negligence legal theories. Under such an interpretation of the Notice of Claim and under this theory there is at least a triable issue of fact as to the duty and breach of duty component of the negligent theory per Civil Code §3428.

Despite there being triable issues of fact as stated above, in order for Claimant to prevail, there must be causation and actual damages. In this regard, Claimant has not submitted any evidence, even with the opposition being construed as broadly as possible, on these two elements of the possible causes of action of negligence and intentional misconduct . There had been a prior ruling at the December 22, 2016 Summary Adjudication hearing regarding the claim that there was no causation element proved by Claimant. (See Notice of Ruling, December 22, 2106, Issue 3). It is thus the law of this case that there is no damage that can be linked casually in terms of actual healthcare provision or non-provision to decedent that had any role in any of his later claimed damages, including his death. For claimant to attempt to now argue that the improper re-enrollment led to his later health

related damages, the prior ruling bars such a claim as it has already been adjudicated. The arbitration damages Claimant Estate seeks are barred by the prior ruling of December 22, 2016.

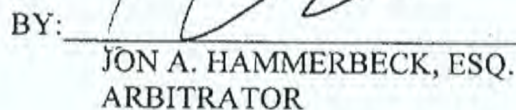
This applies as to either a negligent or intentional improper re-enrollment claim. Claimant Estate conceded in oral argument that it had no other actual proof of actual damages for the remaining Claimant, the Estate, that would have any bearing or relevance as to this motion. Thus, the Estate Claimant has not provided any evidence on the causation or actual damages elements under either a negligent re-enrollment or intentional re-enrollment claim under Civil Code §3428. Thus, there are no triable issues of fact. With there being no triable issues of fact as to the existence of causation or actual damages, the improper re-enrollment must fail as a matter of law, and thus the Motion for Summary Judgment as to the Estate shall be granted.

Given this ruling and the prior ruling regarding Summary Judgment for Respondent against claims, this now disposes the claim entirely, Claimants recover nothing from Respondent.

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.

Dated: March 30, 2017

FORD, WALKER, HAGGERTY & BEHAR



BY: ______________________

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7 IN THE MATTER OF THE ARBITRATION BETWEEN
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9 10 , Ph.D., et al. 11 Claimant, 12 vs. 13 14 , et al. 15 Respondent. 16 17	No.: 13737 **NOTICE OF RULING RE: CLAIMANT'S EX PARTE REQUEST FOR RECONSIDERATION OF ARBITRATOR'S RULING GRANTING RESPONDENT'S MOTION FOR SUMMARY JUDGMENT** Arbitration Demand: September 1, 2015

18 TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

19 The Claimants Ex Parte request for reconsideration of the Arbitrator's ruling granting the
20 Respondent's Motion for Summary Judgment on March 31, 2017, came on regularly for hearing by
21 telephone conference call at 12:10 p.m. on May 17, 2017. Dr. for Claimants and
22 for Respondent were participants on the call.

23 Based on the Ex Parte documentation submitted by Claimants on April 24, 2017, the
24 opposition served by Respondent on May 5, 2017, and the oral argument made on May 17, 2017 the
25 Ex Parte request for certain Estate of medical bills to be paid by Respondent in this
26 matter is denied. While Dr. as putative representative for the Estate has standing to bring such
27 a request, there was not sufficient evidence presented to meet the burden required under either
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California Code of Civil Procedure §1008(a) or California Code of Civil Procedure 1284. The only evidence was the 1 1/2 page Ex Parte itself which referenced bills, and a reference during oral argument to bills submitted earlier. This is not sufficient to meet the burden required of a moving party for reconsideration under these statutes, or any other. Even if the documents submitted and referenced (after the hearing on motion) by Claimant are considered as well, the burden is not met.

In addition, as the opposition states, this Ex Parte request under either statutory provision cited above, or under any other legal or equitable theory, is untimely under the circumstances. This alone justifies the denial of the application.

The application also does not meet the requirement under California Code of Civil Procedure 1008(a) as providing evidence of "new or different facts, circumstances or law". Nothing is presented in the documents submitted or during argument on May 17, 2017 to meet this element, even considering the post hearing documents submitted by Claimant. Thus, the summary judgment rulings made on December 22, 2016 and Marcy 31, 2017 still apply. The insufficient evidence does not address the bases of the rulings and the entirety of the claims of both Dr. and the Estate of are denied. The entire matter remains entirely disposed, with Respondent prevailing on all claims by all claimants and Claimants recovering nothing from Respondent in this matter. This matter, No. 13737 is entirely resolved.

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.

Dated: May 19, 2017

FORD, WALKER, HAGGERTY & BEHAR

BY:______________________________
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