

# On Your Behalf ...

## Legislative and Practice Affairs Division

### Case Holding Surgeon Liable for Nurse's Acts Applicable to CRNAs?

By David E. Willett, Esq., CSA Legal Counsel



Earlier this year, the California Supreme Court refused to review the Second Appellate District's decision in *Fields v. Yusuf*, 144 Cal.App.4th 1381. That suit had been brought by a patient whose leg was amputated after a sponge was left behind during surgery performed by Dr. Yusuf. Dr. Yusuf had argued that he was entitled to rely on the nursing staff's sponge count. Although most commentators have regarded "captain of the ship" as an outmoded basis for imposition of liability on surgeons, the appellate court concluded that Dr. Yusuf had a nondelegable duty to see that all sponges are removed before the incision was closed, relying on both a 1936 Supreme Court decision and the "captain of the ship" doctrine. Although Dr. Yusuf argued that this doctrine should no longer be recognized, the court did not agree. Its decision finds that the surgeon remains liable for the negligence of persons subject to the surgeon's supervision and control during the operation, as "captain of the ship."

In discussing the degree of supervision and control which the surgeon must exercise, the court cited cases distinguishing responsibility for the acts of nurses from responsibility for the actions of anesthesiologists. In *Kennedy v. Gaskell* (1969) 274 Cal.App.2d 244, it was held that the surgeon is not liable for the acts of the anesthesiologist. The court reasoned imposing such a responsibility "... could have mischievous results. It would not only permit but command that a specialist in one field of medicine—surgery—must supervise the precise manner of performance by a practitioner in another specialized field—one in which ever-increasing scientific knowledge demands greater and greater expertise."

It is now an open question whether the courts might hold a surgeon responsible for the acts of a CRNA, under the rationale of *Fields v. Yusuf*, or whether surgeons will successfully argue that *Kennedy v. Gaskell* should be extended to apply to nurse anesthetists. The difference, of course, is that California requires nurse anesthetists to be supervised by a physician. After CSA sued the Board of Registered Nursing for promulgating a policy statement asserting that nurse anesthetists are not subject to a requirement for physician supervision, and are

“independent” practitioners, the Board withdrew the statement, with the comment that no reliance should be placed upon its earlier declaration. Repeatedly, the Attorney General has described requirements for physician supervision of registered nurse anesthetists. Furthermore, Medicare’s Hospital Conditions of Participation require physician supervision of CRNAs unless the state completes an opt-out process—which has not occurred in most states, including California. Unlike an anesthesiologist, a nurse anesthetist is not a specialist in a field of medicine, as described in the Kennedy decision. The CRNA does not practice medicine, but engages in the administration of anesthesia within the practice of nursing. Particularly if the event causing injury reflects that the nurse anesthetist “does not know what she does not know,” the stage is set for a finding that the surgeon’s responsibility encompasses the obligation to be cognizant of the nurse anesthetist’s limitations, and to take or direct action necessary to protect the patient. The court’s justification for applying the “captain of the ship” doctrine in *Fields* was that “A helpless patient on the operating table who cannot understand or control what is happening reasonably expects a surgeon to oversee her care and look out for her interests.” In a setting where no other physician is providing actual supervision for the CRNA, the surgeon must recognize the responsibilities that may arise. The decision in *Fields* has given new vitality to the “captain of the ship” rule.

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### A Tipping Point on Balance Billing?

*By William E. Barnaby, Esq., and William E. Barnaby, III, Esq., CSA Legislative Counsel and Advocates*

#### Introduction

So-called “balance billing” seems to be one of those healthcare issues that just won’t go away. It has waxed and waned as a hotly contested issue before the Legislature, and it continues to be pressed by the Department of Managed Health Care. In a rulemaking rerun, DMHC again is trying to ban balance billing for emergency services rendered to patients on an out-of-network or noncontracted basis by hospital-based and on-call physicians. A recent DMHC hearing in Sacramento was a rather sparsely attended and tepid affair.



“Balance billing” in this context occurs when payers fail to pay any or all of billed charges for out-of-network or noncontracted services rendered, and

patients then are billed for the unpaid balance. Unfortunately, many insured patients have been misled into believing their coverage is more extensive than it actually is. So they are surprised, even angry, to be billed for a service they thought already had been paid. Sometimes helpful are accompanying messages asking the patient to seek a more adequate payment from the insurer. HMOs and PPOs under DMHC jurisdiction are required to have provider payment appeal processes in place, but they have proved to be of limited assistance.

### **Public Hearings as Part of Rulemaking**

Rulemaking is required to be open to public comment but not necessarily to verbal testimony at public hearings. Written comments suffice and often have more impact, as discussed below. When originally announced, no hearings were proposed on the new balance billing package (2007-1253 Plan and Provider Claims Settlement). CSA and CMA formally requested public hearings and DMHC scheduled three, one each in Burbank, Sacramento, and San Diego. The final decision on proposed regulations is made by the Office of Administrative Law on the basis of the written record submitted. The Administrative Procedures Act sets forth the criteria that proposed rules must meet. Basically, these criteria include such things as underlying statutory authority, clarity, necessity, consideration of alternatives, and the like. These same criteria can also serve as the legal basis to challenge the rules, if promulgated, later in the courts. The written record thus becomes all important to the final outcome.

### **Why were fireworks lacking on this very controversial matter at the Sacramento hearing?**

Perhaps the arguments had been aired so many times there wasn't much new to say. Because written comments form so much of the evidentiary record, perhaps verbal testimony wasn't seen as having due impact. Or perhaps some interested parties feel that DMHC, the proposal's sponsor, had already made up its collective mind, thus rendering the hearings as mere formalities.

One difference between the 2006 DMHC proposal and the 2007 package is the addition of an "interim expedited" payment of disputed claims at 150 percent of the applicable Medicare rate. Disputed claims would be adjudicated through an "Independent Dispute Resolution Process" administered under contractual arrangements with DMHC.

CMA President-Elect Dev GnanaDev, M.D., was the first physician witness. Among other points, he urged DMHC to regulate HMOs in the manner used in Colorado and New Jersey (protecting patients rather than insurers) instead of trying to regulate the providers who render the care. He also emphasized the

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diminishing availability of expensive emergency care, such as burn units, due to payment problems. And he termed the use of Medicare reimbursement levels as a basis for private sector payments as “unconscionable.”

The testimony of **CSA President Virgil Airola, M.D., and District 4 Director Christine Doyle, M.D.**, was well received and was complimented by Donald Moulds, the new CMA Vice President for Policy. They calmly presented a compelling case of the adverse impact on patient access that would ensue if balance billing were prohibited.

**CSA member David Black, M.D., of Oakland** gave pointed testimony about the steps his group takes to negotiate contracts with health plans and, for those insured patients whose care nevertheless is rendered on a noncontracted basis, the lengths taken to avoid undue patient financial hardship. He also patiently explained to DMHC Director Cindy Ehnes that Medicare is about 20 percent of California UCR, while 150 percent of Medicare is about 30 percent of UCR and about 40 percent of existing discounted HMO contracts.

The California Chapter of the American College of Emergency Physicians (CAL/ACEP) spokesmen pulled no punches. They vehemently criticized the proposed rules both in substance and for forcing repeated testimony and documentation. They referenced a similar exercise a year ago when DMHC never even responded to the data and policy arguments made then.

An elderly solo family-practice physician from rural Humboldt County was critical of DMHC for not properly regulating insurers. Once able to see almost 50 patients a day, government and managed care paperwork demands now limit his rural clinic to about 20 patients per day.

Virtually every physician witness, especially the CSA representatives, hammered home the theme that the Medicare fee structure is a totally inappropriate and flawed basis for “interim” payments or for assessing the adequacy of insurer/RBO (Risk Bearing Organization) payment levels. Because existing health plan contracts of anesthesiologists and emergency physicians are considerably above the 150 percent of Medicare level, the proposed regulations would discourage contracting and likely lead to cancellation of existing contracts.

The hearing’s initial witness represented emergency air and ground transportation. He viewed the regulations as far more likely to harm the emergency care system rather than to help it. He urged the *proposed* regulations be dropped.

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Testimony on behalf of the California Hospital Association recommended that DMHC put the proposal on hold while the CHA-supported Governor's health plan is under legislative consideration.

No one testified in strong support of the proposed regulation package, other than a "consumer advocate" who simply wanted to prevent patients from being billed after they had "assumed" their HMO plan covered everything. CAPG (California Association of Physician Groups) representatives offered some data and supportive remarks but apparently they are relying more on written comments. The hearing ended before noon, taking less than two hours. The audience never exceeded 30 to 40.

Around the Capitol these DMHC hearings are viewed as a "drill," meaning an exercise that is unlikely to result in any real action. The health plans—the entities that are supposed to be regulated by DMHC—often don't even bother to show up. CAPG, representing the medical groups whose capitation deals with health plans "bear risk," would love to end balance billing apparently to minimize their "risk." They don't need to say much either since DMHC has long been on their side. It is no coincidence that a revolving door has existed for the past several years that has officials matriculating between DMHC, the California Association of Health Plans (CAHP) and CAPG. It often looks like one big happy family.

### Pro and Con Arguments

Superficially, a beguiling case can be made that balance billing subjects patients to unexpected payment demands from overreaching practitioners. Examined more closely, reality shows that it is the insurers and managed care plans that cause balance billing. Some, such as Blue Shield and Blue Cross, send payment checks to patients rather than to the physicians who have rendered the care. Many patients don't understand these checks are intended to pay for their care and are reluctant or even resistant to forwarding these checks to their treatment provider(s). The carriers and plans have already collected subscribers' premiums, have the money in hand, and are in a position to determine when and how much to pay caregivers. The physicians and other providers, however, have rendered the care and cannot take it back. Experience has shown that insurers are more likely to respond to a subscriber's request for a more adequate payment than a plea or appeal from a provider.

The situation is sometimes aggravated by insurers telling patients their underpayments meet *their* version of customary and reasonable levels.

Another often-ignored fact is that most physicians, including CSA members, would greatly prefer to contract with health insurers and RBOs instead of

having to care for patients on a noncontracted basis. Even at discounted payment rates, timely cash flow and minimal administrative hassles frequently are important considerations in negotiating contracts. At the same time, the trend toward mergers and consolidation of healthcare insurers and managed care plans has strengthened the clout of payers.

The legality of balance billing has been tested in the courts. Two California appellate cases have upheld the right of physicians to be reimbursed reasonably for noncontracted emergency services rendered. [See *Bell v. Blue Cross* (2005) and *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2006).] Earlier this year, the *Prospect* case was accepted for further review by the California Supreme Court, where it is pending. A decision is not expected until mid to late 2008.

For the past several years, legislation has been introduced to ban or restrict balance billing. None has passed. Three measures of this sort will carry over from 2007 to the 2008 session. Despite these court decisions and the total absence of statutory authority to ban or restrict balance billing, DMHC continues down this path. It maintains a mindset evidenced earlier when the HMO regulatory authority was vested with a Division of the Department of Corporations.

The situation involving the proposed DMHC package becomes even more egregious as it pertains only to out-of-network or noncontracted *emergency* services. And it applies only to hospital-based physicians and on-call specialists. By force and penalty of law, these services must be provided or physicians can be subject to civil fines and license sanctions. In contrast, payers who flout the “prompt and fair” payment provisions of existing law receive only penalties and sanctions that amount to little more than a slap on the wrist, if that. For too long, minimal penalties have become small costs of doing business to these mostly for-profit, publicly traded health insurers. In sum, the penalties are far too little compared to the ill-gotten profits to alter payer behavior!

### Conclusion

CSA has been in the forefront of this fight for years, along with CMA and CAL/ACEP. It is a fight to prevent health insurers from further undervaluing physicians' services. It is a fight to prevent the balance of negotiating leverage between physicians and payers from being tipped more to the advantage of payers. It is a critical fight about health care policy being battled mostly in the political arena. It is a fight that will have major consequences for access, quality patient care and the caliber of anesthesiologists for the next generation.

### Senate Bill 620— Physician-Administered Anesthesia in the Dental Office, Revisited

By Michael W. Champeau, M.D.,  
CSA President-Elect



As most CSA members are aware, the passage of AB 595 in 1996 prohibited the administration of general anesthesia and deep sedation by physicians in unaccredited facilities. Although a handful of oral surgeons in the state have had their offices accredited by the American Association for Ambulatory Health Care (AAAHC), the overwhelming majority of dental offices in the state are not accredited facilities in the eyes of AB 595. Thus, an unintended consequence of this consumer-oriented legislation was the fact that dentists with General Anesthesia (GA) Permits issued by the California Dental Board could administer general anesthesia in dental offices, while anesthesiologists could not.

AB 745, passed in 1998, addressed this problem, establishing the process by which the Dental Board would grant Medical (as opposed to Dental) General Anesthesia (MGA) Permits to anesthesiologists, allowing them to practice in dental offices, and clarifying to the Medical Board that such practice was not a violation of AB 595. In order to receive an MGA permit, an anesthesiologist must provide the Dental Board with proof of both medical licensure in the State of California and the successful completion of residency training in anesthesiology. The anesthesiologist must also formally attest to the availability and appropriate use of various pharmaceuticals and equipment, such as pulse oximetry, during the administration of each anesthetic. After being granted the MGA permit, the anesthesiologist must submit to an Onsite Inspection and Evaluation of his or her practice no less than once every six years. **The resulting system has worked extremely well for all stakeholders: the anesthesiologists who desire to practice in dental offices, the dentists who choose to have physician-administered anesthesia in their offices, and the citizens of the state of California who have access to high-quality health and dental care.**

The law that created this system, AB 745, was scheduled to expire at the end of this year, and it needed to be extended in order for the program to continue. The CSA worked closely with the various legislative and administrative stakeholders to craft a solution continuing the current practice. Toward that end, a legislative vehicle, SB 620, was introduced to renew the MGA permit program

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established by AB 745. While generally quite supportive of the MGA program, the Dental Board has had some concerns that it had struggled to administer the existing law fully, due to logistical difficulties in conducting the Onsite Inspection and Evaluation of each MGA permit holder as expressly required by the law.

The onsite inspection and evaluation consists of three major components: inspection of the equipment and pharmaceuticals at the site to ensure they meet the requirements of the law, observation of the administration of an anesthetic by the applicant, and the performance of several mock emergency scenarios by the applicant and the dental suite staff. While some may wonder why physician permit holders who are already Board Certified in Anesthesiology need undergo this Onsite Evaluation, I can only say that this is the same process the Dental Board requires of its dentist permit holders, and it is entirely through the Dental Board's cooperation that physicians have obtained an exemption from the restrictions of AB 595.

The Dental Board was having particular difficulty in identifying physician permit holders willing to serve as evaluators for the program. The current law specifically states that at least one of the two examiners conducting the Onsite Inspection and Evaluation for a physician applicant must be the holder of an M.D. degree. So far, the burden of this has been borne by a handful of double-degree—D.D.S. and M.D.—oral surgeons, who are compensated only nominally for their services. The Dental Board asked CSA's assistance in identifying additional physician permit holders who might be willing to fulfill this important role. Additionally, the perceived procrastination of many unevaluated permit holders in scheduling themselves for the required inspections frustrated the Dental Board staff.

On May 23, Mr. William Barnaby, Sr., and I attended a meeting in Sacramento of representatives of the California Dental Board, the California Dental Association, and the California Association of Oral and Maxillofacial Surgeons regarding the issues surrounding SB 620. We were hopeful that CSA's assistance in helping the Dental Board fulfill its mandated duties at the meeting would enhance support within the dental community for passage of the bill. I agreed to communicate with CSA members who hold General Anesthesia Permits and urge them to participate in the onsite evaluation program to the fullest extent. My letters generated several positive responses to the Dental Board, both offers to serve as evaluators and requests to schedule the required evaluations. Subsequently, SB 620 passed through the Legislature on the consent calendar and was signed into law by Governor Schwarzenegger. I urge any readers with MGA permits who are willing to serve as evaluators to contact Virginia Marquez ([Virginia\\_Marquez@dca.ca.gov](mailto:Virginia_Marquez@dca.ca.gov)) of the Dental Board.