THE QUARTERLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

Third Annual CAPtivating Causes Awards to Highlight Members' Efforts to Battle COVID-19

CAPtivating Causes offers an opportunity to highlight the selfless projects and service that our members have undertaken to provide critical medical care to patients during this unprecedented time. In this third year of CAPtivating Causes, CAP is especially interested in hearing about what our members did or are now doing to battle the ravages of COVID-19.

CAP will present the organization's **Community Hero Award** to a CAP member whose charitable service merits special recognition. The award will include a $5,000 grant for the charitable organization affiliated with the physician's work. One runner-up will receive the **Community Leadership Award**, which will include a $1,000 grant for the recipient's associated charity.

> If you are interested in celebrating the work of a fellow CAP member who has made significant contributions to a charitable cause in fighting COVID-19 by offering his or her time, talents, leadership, and service, you may **submit your nomination to Communications@CAPphysicians.com**. Self-nominations are welcome.

Nominations must include:

- Name of physician
- Statement summarizing charitable service

The deadline for nominations is August 31, 2021. CAP membership is required to qualify as a nominee, and the affiliated organization must be an appropriate charitable organization. If there is a physician you would like to refer for CAP membership, please contact Membership Development at 800-356-5672 or MD@CAPphysicians.com.

After a thorough vetting and selection process conducted by CAP employees, the CAP Membership Education and Engagement Committee, and CAP's Board of Directors, selections will be announced by December 31, 2021 and award payments will be issued no later than January 2022.

July 2021

Case of the Month

by Gordon Ownby

Suit May Proceed Over Long-Delayed Failure to Diagnose Brain Tumor

One of the cornerstones of the Medical Injury Compensation Reform Act (MICRA) is the time barrier after which a suit for medical professional negligence cannot be initiated. The core of MICRA's statute of limitations provides that a suit must be commenced within "three years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first." (Fraud, intentional concealment, or the presence of a non-therapeutic foreign body will extend those deadlines.)

While surgical mishaps and other acute events can provide a clear set of facts to determine whether a plaintiff waited too long to file a suit, undiagnosed conditions continue to challenge California's courts in determining how do deal with a healthcare provider's defense based on the statute of limitations. A recent case from the Court of Appeal provides a fresh glimpse into applying the law to a patient's complaint over a long-delayed diagnosis of a brain tumor. The case arises out of a motion for summary judgment, so the facts relied on by the courts are construed in favor of the plaintiff.

The patient began to complain of headaches in 2004 or 2005 and those headaches became steadily worse over a period of years. He described the headaches as involving a feeling of pressure or constant discomfort — "on a scale of 1 to 10, that was like 5 all the time" and then would "spike up based on acute episodes." During such an acute episode in 2010, the patient's doctor ordered an MRI after the patient experienced blind spots, blurry vision, and left eyelid and lip twitching.

The MRI took place in September 2010 and the radiologist interpreting the report, Dr. R, did not detect any abnormalities.

The gentleman's headaches continued to worsen and between 2010 and 2014 they became "more intense, more debilitating, and more different types," sometimes involving pulsing, sometimes throbbing, and sometimes sharp pain. In 2011, the patient separated from his wife and assumed full custody of his three daughters. He told his physician the he felt overwhelmed, did not sleep well at night, and had trouble concentrating. Also in 2011, he reported to his physician worsening depression and that he had low energy, had difficulty focusing and concentrating, and that his job performance was poor.

He saw a mental health professional during this time and taking antidepressants brought some relief. Leaves of absence from work in 2011 and 2012 were for depression, stress, and anxiety. The patient described experiencing a "brain fog — [for] lack of [a] better word" and headaches that "were both debilitating as well as scary, such as the feeling of electric shock through my brain or a lightning bolt . . . [and] constant pressure [in my head], like it felt like it was going to explode from physical pressure."

He received a demotion at work and was given the opportunity to improve his work performance in 2013.

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Concerned about his condition, the patient asked a physician around 2013 whether he might have a brain tumor. His doctor dismissed the suggestion, saying nothing in the patient's blood work indicated he had cancer and that he had already had a negative MRI. The physician instead suggested the symptoms might be caused by the patient's marital problems and resulting stress.

In 2014, however, the patient's headaches were sometimes incapacitating and his physician referred him to a neurologist. The patient underwent brain imaging in December, with results showing a cyst or tumor of the brain. A re-review of the 2010 MRI then showed a "relatively subtle" mass, which had increased by 2014. The patient underwent surgery to resect the mass, which left adverse physical effects. He served a notice of his intent to bring an action against Dr. R and the imaging group within one year of that surgery and (adhering to another MICRA provision allowing an additional 90 days to initiate actual litigation) filed his lawsuit in early March 2016.

The defendants moved for summary judgment, asking the judge for an immediate dismissal of the suit because of the plaintiff's delay after the September 2010 MRI. The trial judge granted the defendants' request, a decision the plaintiff took to the Court of Appeal.

In seeking a summary judgment, a defendant has the initial burden to show undisputed facts to establish an affirmative defense. Once the defendant meets that requirement, the burden shifts to the plaintiff to show a triable issue of material fact regarding the defense. A judge confronted with alternative interpretations of facts must send a matter to a jury to resolve such "factual" disputes. When the facts are uncontroverted, the judge may make a "summary judgment" ruling from the bench as a matter "of law." As the Court of Appeal in *Filosa v. Alagappan, et al.* explained: "Although the application of the statute of limitations is normally a question of fact, the question becomes one of law when the evidence is susceptible of only one reasonable conclusion."

In crafting its decision, the Court of Appeal focused on the date of the patient's "injury" within the meaning of California law: "The term 'injury' for purposes of [the statute] refers to the damaging effects of the alleged wrongful act and not to the act itself. The injury is not necessarily the ultimate harm suffered, but instead occurs at the point which 'appreciable harm' is first manifested.

"Because the three-year limitations period accrues at the time of the injury, it is the surfacing of appreciable harm that marks the beginning of the three-year period," the court explained. For purposes of the one-year period, the Court of Appeal continued, the discovery of the injury means the plaintiff has discovered "both his or her injury and its negligent cause." The plaintiff "need not be aware of the specific facts or the actual negligent cause of the injury. If the plaintiff has notice or information of circumstances that would put a reasonable person on inquiry notice, the limitation period is activated."

In beginning its analysis, the Court acknowledged its challenge: "When a plaintiff brings a malpractice action based on the defendant's failure to diagnose a latent, progressive condition, identification of the 'injury' is more difficult than in the common case of a health care provider performing a procedure that causes injury." Citing to previous case law, the Court set out the template for its decision: "[A] plaintiff discovers the injury when the undiagnosed condition develops into a more serious condition. With the worsening of the plaintiff's condition, or an increase in or appearance of significant new symptoms, the plaintiff with a preexisting condition either actually (subjectively) discovers, or reasonably (objectively) should be aware of, the physical manifestation of his or her injury."

In first addressing whether the three-year statute of limitations barred the patient's lawsuit, the Court of Appeal said the defendants did not establish undisputed facts to support their position that the patient's injury occurred in September 2010 — the date when Dr. R failed to notice evidence of a brain tumor on the original MRI: "[T]here was no immediate 'damaging effect' apparent on the day [Dr. R] failed to

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diagnose [plaintiff's] brain tumor."

The Court then rejected the defendants' contention that the plaintiff discovered his injury no later than his first medical leave in July 2011. "The evidence is that [plaintiff] suffered constant and debilitating headaches, including acute episodes, both before and after his MRI in 2010, and that his headaches worsened steadily over the many years he complained of them. But a reasonable trier of fact could conclude that events in the months following [Dr. R's] failure to diagnose his tumor were not the manifestation of a more serious condition, but merely the continuation of [plaintiff's] previous condition."

The court explained that not only did the plaintiff testify that his headaches in 2014 were the same types he had experienced in 2010, but the "record contains evidence from which a trier of fact could reasonably infer the increase in symptoms that disrupted [plaintiff's] life in 2011 were caused by factors other than the tumor" such has his wife's serious mental health issues, the end of his marriage, and taking full responsibility for three children. The court also pointed out other symptoms mentioned by the plaintiff plaguing him in 2012 and 2013, including extreme fatigue, eye strain, "brain fog," an inability to concentrate, and difficulty functioning "at a mental executive capacity."

"Although a factfinder might ultimately conclude some of these symptoms were effects of the brain tumor and that appreciable harm from the failed diagnosis manifested more than three years before [plaintiff] brought this action, the record does not permit that question to be resolved on summary judgment."

As for the one-year component of the statute of limitations, the Court of Appeal rejected the defendants' contention that the plaintiff's testimony about increasingly severe headaches would have prompted a person of reasonable diligence to discover his brain tumor. In particular, the defendants pointed to the plaintiff's asking a doctor in 2013 if a brain tumor might account for his conditions. But with plaintiff receiving reassurance from that physician that his blood work and negative MRI history did not indicate cancer, "reasonable minds could easily conclude [plaintiff] did everything within his power to ascertain what, if any, illnesses he had after receiving defendants' initial diagnosis."

Significantly, the Court of Appeal then addressed the suspected negligence component of the one-year period: "Nor does the evidence show unambiguously that even if [plaintiff] suspected a tumor, he knew, or reasonably should have known, that his original MRI was negligently misinterpreted."

Finding that the defendants did not carry their burden to show facts with only "one reasonable conclusion," the Court of Appeal returned the case for a jury's determination on the statute of limitations, adding, "We express no view as to what the evidence will show at trial."

A Note on NSAIDs — We've heard from several members regarding May's "Case of the Month" focusing on a patient's use of Ibuprofen prior to a cervical epidural steroid injection. The intent of "Case of the Month" is not to offer specific guidance on standard of care, but rather to point out risk management strategies that can reduce patient injuries and increase the chance of prevailing in a medical malpractice suit. Though expert review supported having the patient stop the use of blood-thinning medications prior to the CESI, standards of care can be nuanced and subject to change. The risk management lesson in May was to suggest better coordination between the physician and staff as to what pre-procedure advice should be given to patients. For pain management and other specialties, resources on ever-evolving standards of care include specialty-based literature, specialty society guidance, and other continuing medical education tools.

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.

Steven-Johnson Syndrome and Toxic Epidermal Necrolysis Situation

by Monica Ludwick, Pharm. D

There have been several claims involving Steven-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) within the last year, bringing heightened awareness to this rare, but serious illness. With the broad spectrum of potential severity, it is important for physicians to recognize the differences between various cutaneous reactions, identify potential offending agents, and initiate treatment if indicated. The early recognition of severe cutaneous reactions is critical to minimize fatal outcomes and reduce litigation risk.

Background

SJS and TEN are life threatening diseases; however, it is hard to estimate the rare incidence of these diseases. The incidence of SJS is estimated at one to six cases per million person-years.[1]

SJS may begin with fever and flu-like symptoms and progress into a painful purple/red rash that blisters and spreads. Following the appearance of the diffuse rash, the lesions convert to flaccid blisters that spread with pressure and break easily, leading to extensive epidermal detachment. SJS should be treated as a medical emergency, as it usually requires hospitalization.

Approximately 50 percent of cases of SJS and 80 to 90 percent of cases of TEN are drug induced. [2–4] Common causative agents include sulfa drugs, antiepileptic drugs, antibiotics, and nonsteroidal anti-inflammatory drugs.[3–4] Non-iatrogenic associations include infections, vaccinations, radiation, sunlight exposure, pregnancy, connective tissue disease, and neoplasms. The exact pathogenesis of these conditions is unknown. Treatment includes elimination of the underlying cause (if caused by a medication, the patient will have to permanently avoid that drug as well as related drugs), controlling symptoms, and minimizing complications as the skin regrows. Recovery can take weeks to months.[1,3]

Symptoms can sometimes be misdiagnosed or missed altogether, as some of the symptoms can be associated with other common conditions, including the flu, fever, widespread skin pain, reddish or purplish rash that will spread as the disease progresses, blisters all over the skin, shedding of the skin after the blisters form, or lesions on the mucous membranes, usually around the mouth, nose, eyes, and genitals. These symptoms may also present with fever, sore throat, pain in the mouth, nose, eyes, or genitals, extreme tiredness, cough, and burning sensation in the eyes.[5]

SJS and TEN can be hard to distinguish from another skin disease called Erythema multiforme (EM). Erythema multiforme is usually set off by a viral infection (most commonly Herpes simplex virus, but also COVID-19). While SJS/TEN is rare, comparatively, approximately one in five individuals will develop a skin rash associated with COVID-19 illness.[6]

The following chart lists drugs associated with SJS and the respective risk level. Note that the reaction may start anytime while the patient is taking the medication up to a few weeks after discontinuation:[1–5]

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Risk Level	Drugs
High risk	**Antigout:** allopurinol **Antibiotics:** sulfamethoxazole, sufadiazine, sulfadoxine **GI conditions:** sulfasalazine **Anticonvulsants:** carbamazepine, lamotrigine, phenobarbital, phenytoin, fosphenytoin **Antiretroviral:** nevirapine **NSAIDS (oxicam):** meloxicam, piroxicam
Lower risk	**Antibiotics:** aminopenecillins, cephalosporins, quinolones, tetracyclines, macrolides **NSAIDs (acetic acid):** diclofenac **Anticonvulsants:** valproic acid, oxcarbazepine **Antidepressant:** sertraline
Reported cases	Acetaminophen, corticosteroids, other NSAIDs (except aspirin), zonisamide, lenalidomide, acetazolamide, ethambutol, mirtazapine, oseltamivir
No evidence of risk	Aspirin, sulfonylureas, thiazide diuretics, furosemide

The Food and Drug Administration has issued black box warnings, the strictest warning it can place on prescription drugs, describing the risk of serious rashes requiring hospitalization and discontinuation of treatment, in association with most of these risky medications. The warnings also include that SJS/TEN have been reported in a very small percentage of cases. SJS can also be caused by certain infections, such as hepatitis A, herpes, HIV, or pneumonia.

Patients may also be more like to develop SJS with certain risk factors: family or prior history of SJS, HIV, presence of the HLA-B 1502 gene (more common in families of Chinese, Indian, or Southeast Asian descent), and a weakened immune system.[4]

Assessment

The acute management of SJS/TEN requires a multidisciplinary approach. Immediate withdrawal of potentially causative drugs is mandatory. Prompt referral to an appropriate medical center for specific supportive treatment is of utmost importance. The most frequently used treatments for SJS/TEN are systemic corticosteroids, immunoglobulins, and cyclosporine A.

There is currently no evidence that SJS is a side effect of the COVID-19 disease or the COVID-19 vaccines. Data indicate that receiving a COVID-19 vaccine is safer all around than risking natural infection and potential negative skin reactions that could emerge as a result of infection.[6]

Recommendations

- Prompt recognition of SJS and TEN is critical to assure successful management. Diagnosis with biopsy, identification and removal of the causative drugs are critical in early suspicion.

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- Ensure your patient is well informed when starting medications with high incidence of SJS reactions, including reminders to contact you with any signs or symptoms.
- Stay within approved dosing regimens of medications. If higher doses are warranted, explain to the patient that monitoring for any reactions is imperative.
- Remember that most, if not all, of the medications associated with SJS/TEN have black box warnings of the risk.
- Encourage patients to receive the COVID-19 vaccine. There is no evidence to date indicating that patients who have experienced SJS/TEN would be at higher risk of recurrence.

Dona Constantine, a CAP Senior Risk and Patient Safety Specialist, contributed to this article.

Monica Ludwick is a CAP Senior Risk Management and Patient Safety Specialist. Questions or comments related to this article should be directed to mludwick@CAPphysicians.com

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Employee Health Insurance Benefits Available for CAP Member Practices

The cost of healthcare is a constant challenge for all employers, but providing employees with quality health insurance benefits can have a long-term positive impact on your practice.

As healthcare costs continue to rise, the licensed insurance professionals with CAP Physicians Insurance Agency (CAP Agency) recognize that CAP members need flexible options when selecting the right health insurance plans for their practices. That is why CAP Agency has partnered with CAP's health insurance broker Ashbrook-Clevidence to offer valuable healthcare coverage options for CAP members and their employees. Ashbrook-Clevidence has been CAP's health insurance broker for more than 20 years and is a trusted resource.

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3. Employees will often accept better benefits in lieu of a higher salary.
4. Quality healthcare helps everyone stay healthy and productive.

Now more than ever, it is critical to review your plan designs and premium programs to ensure you have the best plan to balance your coverage needs and budget.

The dedicated team at Ashbrook-Clevidence offers enhanced employee insurance programs and solutions to CAP member practices that can help reduce costs and ensure minimal member disruption. Get started by sending them a copy of your current plan so they can do a side-by-side comparison of your current benefits and costs with the market. Ashbrook-Clevidence will also evaluate other benefits you may provide your employees, such as dental and vision insurance. Now, with health insurance added to the mix, you may be surprised by the preferred low rates you can get from CAP Agency's programs, which are specially designed for smaller practices.

Ashbrook-Clevidence works with a variety of insurance companies, including:

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- SHARP
- Blue Shield of California
- Oscar
- Kaiser Permanente
- Sutter Health
- California Choice
- United Healthcare
- And many more!

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We encourage you to reach out to the Ashbrook-Clevidence team and see if they can help you and your employees.

Contact Information:

Chris Clevidence, Ashbrook-Clevidence, Inc. at 714-755-2492 or ChrisC@aclevidence.com

Cristina Burnell, Ashbrook-Clevidence, Inc. at 714-426-1926 or CristinaB@aclevidence.com

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Ask My Practice
by Andie Tena

What You Need to Know About California's New Prescribing Mandate

In 2018, the legislature of the state of California passed Assembly Bill 2789, mandating electronic prescribing for California prescribers beginning January 1, 2022.

The bill requires healthcare practitioners authorized to issue prescriptions to have the capability to transmit electronic data transmission prescriptions, and requires pharmacies to have the capability to receive those transmissions. The bill also requires those healthcare practitioners to issue prescriptions as an electronic data transmission prescription, unless specified exceptions are met.

The bill does not require the pharmacy to verify that a written, oral, or faxed prescription satisfy the specified exemptions. Pharmacies receiving the electronic data transmission prescription are required to immediately notify the prescriber if the electronic data transmission prescription fails, is incomplete, or is otherwise not appropriately received. The pharmacy is also required to transfer or forward the prescription to another pharmacy at the request of the patient, as specified.

The bill exempts from these provisions a healthcare practitioner, pharmacist, or pharmacy when providing healthcare services to specified individuals under the jurisdiction of the Department of Corrections and Rehabilitation. Healthcare

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practitioners, pharmacists, or pharmacies that fail to meet the applicable requirements imposed by this bill will be referred to the appropriate state professional licensing board solely for administrative sanctions, as provided.

There are a few exceptions to the requirements. Though not exhaustive, below are those relevant to Physicians, Nurse Practitioners, and Physician Assistants – i.e. "prescribers."

1. The system used for the electronic transmission is temporarily "down" due to technical or other failure(s), e.g., computer crash, internet service loss, power failure.
2. The Rx will be dispensed by a pharmacy outside the state (California).
3. The Rx is issued in a hospital ER or urgent care and one or more of the following conditions exists:
   - The patient resides out of California
   - The patient resides outside the geographic area of the hospital
   - The Rx is issued at a time when the patient's regular pharmacy is likely closed.

***Note** – this exception appears to apply to ER/Urgent care settings only*

4. The prescriber is also the dispenser, i.e., you dispense medications in your office setting consistent with the dispensing pharmacy rules.
5. The prescriber determines the (clinical) conditions are such that electronic transmission is "impractical" for the patient to obtain the medication in a timely manner and delay would impact the patient's medical condition.
6. A prescriber who does not issue an electronic Rx (per 2 above) must document the reasons in the medical record ASAP or within 72 hours of the end of the technical issues that prevented electronic transmission of the Rx.
7. The rule does not apply to prescribers providing healthcare services to:
   - An inmate
   - Parolee
   - A minor (youth) under jurisdiction of the Department of Corrections and Rehabilitation.

Pharmacies are required to notify prescribers if the transmission failed or otherwise is incomplete (note — this provision presumes their systems are operational).

This article is a brief summary of AB 2789. We encourage you to do a deeper dive by reviewing the body of the stature here: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2789.

Providers must use approved vendors to order tamper-resistant forms from secure prescription printer companies. For more information on obtaining the correct electronic prescriptions for controlled substances, please visit https://oag.ca.gov/cures.

Contact Andie Tena, CAP's Director of Practice Management Services at 213-473-8630 or via email at MyPractice@CAPphysicians.com for assistance.

Andie Tena is CAP's Director of Practice Management Services. Questions or comments related to this column should be directed to atena@CAPphysicians.com.

New Federal Medical Billing Law Does Not Preempt California's AB 72

by Gabriela Villanueva

The No Surprises Act goes into effect January 1, 2022. The new federal law, following much of the blueprint of California's AB 72 enacted in 2017, holds patients harmless from surprise bills, including from air ambulance providers, and prohibits out-of-network providers from balance billing unless they give patients 72-hour notice of their network status and an estimate of the charges.

The new federal law has two main parts. The first protects patients from surprise medical bills, curbing out-of-network balance billing, especially in 18 states that currently have no statutes on balance billing protections. The second part establishes an independent dispute resolution (IDR) process for payers and providers.

The 32 other states, including California, currently have similar statutes and the federal law clarifies it will not preempt state law. Since the federal law does not exactly track AB 72, the law creates implications that California will likely need to contend with. Specifically, the resolution dispute process for providers.

After intense lobbying by industry groups over how to settle payment disputes between healthcare payers and out-of-network medical providers, the new federal law will enact binding arbitration as its IDR process. This was the method favored by doctors and hospital groups, while employers and insurers pushed for settling disputes with payment of a median in-network rate for a particular service or procedure. Here in California, payment between the insurance company and provider is based on either 125 percent of Medicare or the average contacted rate.

Under the new federal law, however, a healthcare provider's previously billed charges and government-payer rates cannot be considered during arbitration, and it does not allow government rate-setting. The legislation does include some provisions intended to encourage in-network agreements and prevent abuse and overuse of the arbitration process. It also does not require a threshold billing amount for arbitration.

To resolve payment disputes through arbitration if payers and providers cannot reach an agreement on their own, either side may ask for arbitration. Both sides would then make an offer, and an independent third-party arbitrator would pick one. In reaching a decision, the arbitrator would have to consider several factors, including:

- The median in-network rate
- Information related to the provider's training and experience
- The parties' market concentration
- Previous contracting history between the parties
- Complexity of the services provided

Prohibited from the arbitrator's consideration are:

- Government payment amounts (Medicare/ Medi-Cal)
- Billed amounts or charges

Many unanswered questions remain and it will be up to the Department of Health and Human Services (HHS), through its rule making process, to attempt to answer them. It is expected that HHS will issue an "interim final rule with comment period" sometime in July, subject to future modification based on comments received.

In the meantime, lobbying in some states is underway to bring states laws into parity with the new federal law. In which case, we should ask if the same should happen in California.

Gabriela Villanueva is CAP's Government & External Affairs Specialist. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

Public Policy

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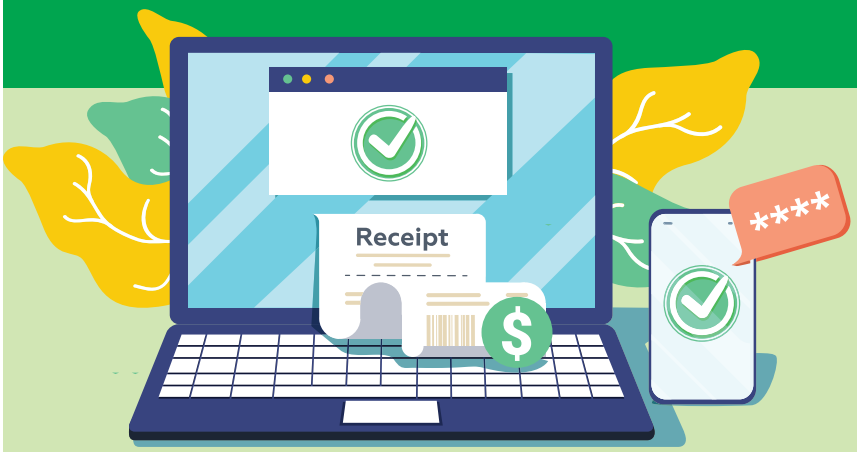

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3. Select the "Via Email Only" button.
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