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November 2022

Case of the Month

Court Backs PA's License Revocation Over MD Supervision Setup

This month, we feature a popular "Case of the Month" from the archives written by CAP's former General Counsel Gordon Ownby

The California Court of Appeal has ruled that a physician assistant's practice arrangement attenuated his required physician supervision so as to amount to the unauthorized practice of medicine.

Rodney Eugene Davis, a physician assistant, set up a liposuction business and met with an anesthesiologist, Jerrell Borup, MD, to provide the physician supervision of his activities required under California Business & Professions Code Section 3502. Dr. Borup practiced anesthesiology beginning in 1982 but stopped practicing medicine in 1998 after suffering a stroke. When Davis and Dr. Borup met in 2010, Dr. Borup had recently joined the American Academy of Anti-Aging Medicine and had attended approximately six weeks of didactic training meetings with the Anti-Aging Academy in Florida. After the meeting with Davis, Dr. Borup attended a liposculpture program consisting of a week of video and didactic instruction followed by a weekend consisting of two unnamed procedures under the observation of a "teacher."

Davis hired Dr. Borup as the office's "Medical Director" while Davis took the title "Director of Surgery." The office opened in September 2010. In 2015, however, the California Physician Assistant Board filed an accusation against Davis accusing him of unlicensed practice of medicine, gross negligence, misleading advertising, and other charges.

During the Board proceedings, witness Dario Moscoso, the administrator and chief financial officer for the business set up by he and Davis, testified on meetings that he attended with Davis and Dr. Borup. At the first meeting, Moscoso testified that Dr. Borup said he was not interested in performing liposuction, to which Davis responded that he would be performing all the liposuction procedures himself and that Dr. Borup's role would be an "off-site type of supervisory experience." Moscoso testified that at a second meeting two weeks later, the three discussed the "structure" of the arrangement—"that [Dr. Borup] could be away from the office and should be away from the office enjoying his retirement."

According to Moscoso's testimony, Dr. Borup would come into the office once or twice a month. In his own testimony, Dr. Borup said he did not perform a single procedure at the business and that the full extent of his liposuction surgery experience was the weekend training session "and what [he] observed."

In Davis' testimony before the Board, he recounted that he learned how to do liposuction procedures while working at the office of an interventional radiologist and that he performed "several thousand procedures" under that physician's supervision. Two years later, Davis performed liposuction procedures daily at a practice owned by another physician.

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In his testimony before the Board on setting up a new business, Davis said he "preferred to be the primary provider of lipo." Davis said that during the initial discussions regarding Dr. Borup doing procedures, he said, "'I want to get this off the ground. Let me get this going, of course, under your supervision. But I know that we need to have good photos on the website. We need to have good reviews.'"

Davis continued in his testimony that he was very confident he could get good results himself and that "it seemed more straightforward to just have the person whose work is displayed on the site" perform the procedures. "I think we can avoid more problems by making sure we stay consistent with that versus having Dr. Borup . . . practicing on people just for the sake of practicing . . . ."

In 2016, the Board adopted the proposed decision of its Administrative Law Judge revoking Davis' physician assistant license after finding by "clear and convincing evidence" that Davis had engaged in the unlicensed practice of medicine. In finding that Davis practiced medicine without a license, the ALJ found: "Throughout the hearing [Davis] made it clear that he resented performing liposuction surgeries for doctors who he felt were less qualified than him, and who made their living from his work, skills and talents . . . [T]o have the control he wanted and get the pay he believed he deserved. [Davis] purposefully . . . set out to create a business arrangement that looked legitimate on paper, but allowed him to . . . run a liposuction business without the interference of a physician."

Davis was unsuccessful in seeking a reversal of the Board's decision by a Superior Court judge and on appeal asserted that he had no intent to practice medicine without a license, did not hold himself out as a physician, and had a delegation of services agreement with Dr. Borup, who he argued had sufficient knowledge and ability to serve as his supervising physician.

The Court of Appeal in Davis v. Physician Assistant Board began its analysis of the matter by emphasizing the terms in California Code of Regulations Section 1399.545(b): "'A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.'" The appellate court said that substantial evidence supported the ALJ's finding that Dr. Borup "improperly delegated medical tasks and procedures" to Davis.

The Court of Appeal continued its analysis by emphasizing that the relevant regulations also provide, "'The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously.'" Here, the Court focused on an email from Davis to Moscoso saying, "I hope that [Borup] will be able to stick with our system once has [sic] some knowledge." Davis also wrote in the email: "We don't want another clumsy physician getting in the way." Though Davis argued that the passage referred to his past dissatisfaction with a physician on staff management issues, the Court of Appeal said that "it could be reasonably inferred from the email that Davis desired and intended to function autonomously at the business, free from any interference in the form of 'another clumsy physician getting in the way.'"

On Davis' contention that he did not have any "intent" on practicing medicine without a license, the Court of Appeal pointed out that statutory language addressing the aiding or abetting of an unlicensed person in the practice of medicine does not include words such as "knowingly" or "intentionally" and quoted with approval another court's conclusion that "reading an intent element into the statute 'would not further the legislative purpose of public protection.'"

Even so, the Court of Appeal concluded that the evidence supports the conclusion that operating autonomously "was Davis' very aim" in the establishment of the liposuction business.

In upholding the Board's finding that Davis practiced medicine without a license, the appellate court commented: "His contention that there was no showing that he had the intent to practice medicine without a license is meritless."

California public records show that Dr. Borup's medical license has been surrendered.

Risk Management and Patient Safety News

Recording Office Visits: Is it Right for Your Practice?

by Deborah Kichler, RN, MSHCA

Look around your waiting room. You'll likely find most patients on their phones texting, emailing, surfing the internet, or listening to music or podcasts. In this age of continuous real-time and on-demand media, how do you know whether your patients are also using their devices to record their office visit without your knowledge or consent? Should patients be allowed to record these visits?

It is understandable why some patients would want to record their office visit. The time with the physician is often brief and patients may feel rushed. In addition, patients may be overwhelmed by the amount or nature of what is being discussed and may have difficulty understanding and retaining diagnoses and follow-up instructions. Or perhaps they simply want to share the information discussed with a family member or friend.

While physicians might not be comfortable with the idea of being recorded, there are some definite upsides, including increased patient engagement and compliance with care. However, there always must be consent between doctor and patient.

Fear of litigation, loss of privacy, and the threat of publication on social media are valid concerns for the provider.[1] The physician-patient relationship is a partnership of trust. Any secret recordings would undermine that trust and could inhibit open disclosure of more sensitive information or admission of certain problems during their visit. While the federal wiretapping law (18 U.S. Code § 2511) requires only one person consent to record a conversation,[2] California requires that all parties must consent to recording a conversation. Secretly recording physician visits is illegal in California.[3] Therefore, recording a physician visit would not be allowed without the physician's consent.

What about confidentiality issues? The HIPAA Privacy Rule is designed to protect patients' health information from accidental or intentional disclosure by healthcare providers, but these regulations do not prohibit patients from disclosing their own protected health information (PHI), so long as it does not violate another party's rights. Of course, if the physician records a patient encounter, HIPAA requires that the recording must be protected in the same manner as any other PHI. (For specific questions or concerns about HIPAA violations, we recommend consulting a healthcare attorney.)

Establishing Policies and Procedures

Regardless of whether you permit or prohibit video recording in your practice, it is prudent to develop clearly defined policies and procedures that protect patient privacy and honor the physician-patient relationship. Some tips to get started:

- Make sure that all patients receive and sign a copy of your video/audio recording policies. Include these with your new patient intake materials or distribute them to existing patients upon check-in. Be sure to scan and keep the electronic signed copy in the patient's medical records.

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- In your recording policy, be sure to address your office's position on patient and provider recording of visits.
- If you do allow recording of visits, explain under what circumstances a recording may be done, and by whom.
- If the physician/medical staff is recording the visit, include a consent form that fully discloses the purpose of the recording, who can view it, where it will be stored, and for how long.

For those practices that do not want to allow recordings of any kind, we recommend you post a highly visible, easy-to-read sign at the practice entrance or check-in area that clearly states: **"This office strictly prohibits electronic recording or videotaping of any kind in consideration of the privacy and confidentiality of the physician-patient relationship. We sincerely appreciate your compliance with our request."**

If you are interested in a secure, HIPAA-compliant application that allows you to record clinical visits or provide video educational materials to your patients, please consult the CAP Marketplace at: **https://www.capphysicians.com/practice-management/practice-management-services/cap-marketplace**

Deborah Kichler is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to DKichler@CAPphysicians.com

Additional Resources:

"Secretly Recording Your Doctor's Appointments. "Naveed Saleh, MD, MS, June 8, 2020. https://www.verywellhealth.com/secretly-recording-your-doctor-appointments-4145786

"What to do When Patients Want to Record Their Doctor Visits." Richard Cahill, J.D., March 1, 2017. https://www.thedoctorweighsin.com

"Can Patients Record Doctor's Visits? What Does the Law Say?" The Dartmouth Institute for Health Policy & Clinical Practice, July 10, 2017. https://www.sciencedaily.com/releases/2017/07/170710135301.htm .

References:

[1]Audio-Video Recording of Patient Visits. Jeffrey A. Woods, JD. The Sentinel, July 2018. home.svmic.com/resources/newletters/145/audio.

[2]"State, federal laws govern whether doctor visits can be recorded." Laura J. Sigman, MD, JD, FAAP, April 30, 2019. www.publications.aap.org/aapnews/13600.

[3]Cal. Penal Code § 632(a) https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN§ionNum=632

New Healthcare and Employment Laws Physicians Need to Know

by Gabriela Villanueva

Public Policy

Earlier this fall the California legislative session concluded with 997 new bills enacted into law. Below is a summary of those bills that may be of immediate interest to physicians in their roles as healthcare providers and employers.

New Labor and Employment Laws

On January 1, 2023, the minimum wage in California is increased to $15.50 per hour, for all employers—regardless of the number of workers employed by an employer. Also, many cities and local governments in California have enacted minimum wage ordinances exceeding the state minimum wage.

SB 1126, authored by Senator Dave Cortese (D-San Jose), expands the definition of "eligible employer" to include any such person or entity that has at least one eligible employee and that satisfies the requirements to establish or participate in a payroll deposit retirement savings arrangement, e.g., a 401(k) plan. Excluded from the definition of "eligible employer" are sole proprietorships, self-employed individuals, or other business entities that do not employ any individuals other than the owners of the business.

This bill further requires eligible employers with five or more employees that do not offer a retirement savings program, to have a payroll deposit savings arrangement to allow employee participation in the program within 36 months after the CalSavers Board opens the program for enrollment. By December 31, 2025, eligible employers with one or more eligible employees that do not provide a retirement savings program, are required to have a payroll deposit savings arrangement to allow employee participation in the program.

SB 1162, authored by Senator Monique Limon (D-Santa Barbara), requires employers with 15 or more employees to disclose pay scales for a position in any job posting and requires employers to maintain records of job titles and wage rate history for each employee for the duration of employment plus three years. It also sets new pay data reporting requirements based on protected characteristics, changes the date for submitting pay data reports, and establishes significant civil penalties for non-compliance. A more detailed overview can be seen here: **https://www.faegredrinker.com/en/insights/publications/2022/9/california-legislature-passes-pay-transparency-law**

AB 1041 authored by Assemblyperson Buffy Wicks (D-Oakland), expands the class of people for whom an employee may take leave to care for under the California Family Rights Act (CFRA) to include a "designated person." Under the CFRA, an employer with five or more employees must provide eligible employees who meet specified requirements to take up to a total of 12 workweeks in any 12-month period for family care and medical leave as defined by the CFRA.

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This bill defines “designated person” to mean any individual related by blood or whose association with the employee is the equivalent of a family relationship. Further, this bill provides that the employee may identify the designated person at the time the employee requests Leave and that the employer may limit the employee to one designated person per 12-month period.

This bill also expands the definition of family member under the California (CA) Paid Sick Leave Law to include a “designated person.” Like the provisions of the CFRA discussed above, for purposes of the CA Paid Sick Leave Law, the employee may identify the designated person at the time the employee requests paid sick days and the employer may limit an employee to one designated person per 12-month period for paid sick days.

AB 1949, authored by Assemblyperson Carlos Villapudua (D-Stockton), amends the California Family Rights Act CFRA and provides that eligible employees who have been employed for at least 30 days may take up to 5 days of unpaid leave (subject to an employee’s ability to use available paid time off) related to the death of a family member. Family member means a spouse or a child, parent, sibling, grandparent, grandchild, domestic partner or parent-in-law.

Under this bill, bereavement leave need not be taken in consecutive days, but the bereavement leave must be completed within three months of the date of death of the family member.

To the extent an employer has an existing bereavement policy, the bereavement leave must be taken pursuant to the employer’s existing bereavement leave policy. If the employer does not have an existing bereavement leave policy, the bereavement leave may be unpaid; but the employee may use vacation, personal leave, accrued and available sick leave or compensatory time off that is otherwise available to the employee.

If the employer’s existing leave policy provides for less than five days of paid bereavement leave, the employee is entitled to no less than a total of five days of bereavement leave, consisting of the number of days of paid leave under the employer’s existing policy, and the remainder of days of leave may be unpaid; but the employee may use vacation, personal leave, accrued and available sick leave, or compensatory time off that is otherwise available to the employee.

New Healthcare-Related Laws

SB 1419, authored by Senator Josh Becker (D-Santa Clara), allows patients to receive the results of their "tests" prior to a review by a healthcare professional. The term "tests" has been expanded to include not only clinical laboratory tests, but also imaging scans (e.g., x-rays, MRIs and ultrasounds). This new law requires a health plan and health insurer, commencing January 1, 2024, in order to facilitate patient and provider access to health information, to establish and maintain the application programming interfaces (APIs) for access to patient, provider and payer-to-payer.

SB 1473, authored by Senator Richard Pan (D-Sacramento), requires health plans and insurers to cover therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration (FDA)—to treat COVID-19 or any other disease that the Governor has declared a public health emergency—regardless of the provider’s network status. The bill also prohibits cost sharing and utilization management for such therapeutics, similar to existing rules related to testing and vaccines. SB 1473 also extends the coverage requirements for testing, vaccines, and therapeutics for six months after the end of a public health emergency.

AB 1636, authored by Assemblyperson Akilah Weber, M.D. (D-San Diego), causes physicians convicted of sexual assault with a patient to lose their license with no ability for it to be reinstated. Currently, a physician

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can petition the medical board for reinstatement three years after having their license revoked or surrendered for unprofessional conduct.

This bill removes the discretion from a medical board to give or reinstate a physician or surgeon who lost their license due to sexual misconduct with a patient. This bill would also deny a physician's and surgeon's certificate to an applicant who has been or is required to register as a sex offender.

AB 2098, authored by Assemblyperson Evan Low (D-San Jose), designates the dissemination or promotion of misinformation or disinformation related to COVID-19 by a physician or surgeon as unprofessional conduct, allowing the Medical Board to take action against such physician or surgeon. This bill is intended to target three types of false or misleading information relating ONLY to the COVID-19 pandemic.

- First, the language refers to nonfactual information regarding the nature and risks of the virus—for example, misleadingly comparing COVID-19 to less serious conditions or inaccurately characterizing the deadliness of the disease.
- Second, the bill seeks to address false statements regarding its prevention and treatment—this would presumably include treatments and therapies that have no proven effectiveness against the virus.
- The third category is for misinformation or disinformation regarding the development, safety, and effectiveness of COVID-19 vaccines.

Gabriela Villanueva is CAP's Government and External Affairs Analyst. Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com.

Public Policy

by Andie Tena

New Bill Provides Exemptions for Low-Volume Prescribers

Since California's electronic prescribing mandate went into effect on January 1, 2022, many low-volume prescribers have found that securing a standalone e-prescribe platform or adding on e-prescribe as an electronic health record (EHR) feature has been costly, due to its monthly subscription costs and set-up fees. And those practices still recovering from COVID-19-related losses are being hit hardest.

The California Medical Association (CMA) recognized this burden on physicians and sponsored Assembly Bill 852, which provides exemptions for low-volume prescribers. The bill was recently signed by Governor Newsom.

AB 852 provides exemptions for providers who meet the following criteria:

- Issue 100 prescriptions or less in a year
- Are practicing in an area affected by natural disaster, officially declared disaster, or emergency zone
- Are granted a waiver based on other extraordinary circumstances[1]

If a physician qualifies for at least one of the above exemptions, they must register with the Board of Pharmacy; however, a formalized process has not yet been established, as of the writing of this article.

The implementation of AB 852 will allow providers the flexibility to comply with the e-prescribing mandate and reduce costs for low-volume providers.

For questions regarding the e-prescribe mandate, please see CA.GOV's Frequently Asked Questions at https://pharmacy.ca.gov/licensees/erx-faqs.shtml.

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

[1]https://www.cmadocs.org/newsroom/news/view/ArticleId/49897/CMA-bill-to-provide-more-eRx-flexibility-for-low-volume-prescribers-signed-into-law

Essential Insurance Products to Protect Your Family, Pets, Home, and More!

November 2022

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To learn more about these programs and enroll, contact CAP Agency by calling **800-819-0061** or emailing **CAPAgency@CAPphysicians.com**.

CAP Physicians Insurance Agency, Inc. (CAP Agency) is a full-service insurance agency created to support CAP members with their insurance needs. The licensed, trained professional insurance agents with CAP Agency have expertise in all lines of business and personal insurance coverage, and they know healthcare. They can provide you with a comprehensive review of your risk exposures, assess your current coverage, and provide you with comparative, competitive quotes at no cost to you.

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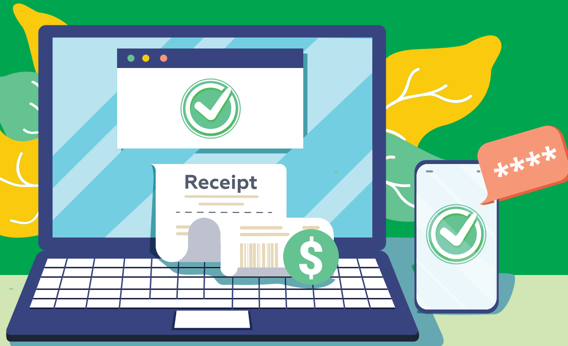

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Here's how:

1. Visit **https://member.CAPphysicians.com** to log into your CAP account.
   Visit **https://member.CAPphysicians.com/register** to create an account if you do not have one.
2. Once logged in, select the green "Set Up Paperless Billing" button.
3. Select the "Via Email Only" button.
4. Verify your email address and click the "Save Changes" button.
5. Then, click on the "Pay CAP Bill" button. (Agree to the terms and conditions when prompted)
6. Click on the "Set Up Autopay Payments" button and select the "New Bank Account" option under the payment method drop down menu.
7. Provide the required information to complete your enrollment.

For assistance with your account or if you have questions about your membership, please call **800-610-6642** or email **MS@CAPphysicians.com**

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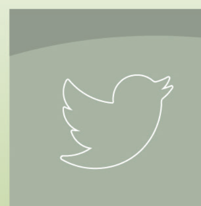

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