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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

TERRY J. LARUE, Plaintiff, Appellant and Cross-respondent, v. ACCOUNTABLE HEALTH CARE, IPA, INC., Defendant, Respondent and Cross-appellant.	B285281 (Los Angeles County Super. Ct. No. BC566095)

APPEAL from a judgment of the Superior Court of Los Angeles County, Malcolm Mackey, Judge. Affirmed as modified.

Law Offices of Robert S. Gerstein and Robert S. Gerstein; Gianelli & Morris, Robert S. Gianelli, Joshua S. Davis and Adrian J. Barrio; The Kern Law Group, Rene J. Kern, Jr. and Gaetano J. Verrastro for Plaintiff, Appellant and Cross-Respondent.

Grignon Law Firm, Margaret M. Grignon and Anne M. Grignon; McClelland Advocacy and Michael D. McClelland for Defendant, Respondent and Cross-Appellant.

Plaintiff Terry Larue suffered a hand injury for which treatment was unreasonably delayed by his health plan's administrative approval process. He brought suit against Health Net of California, his health insurer; and Accountable Health Care IPA, the independent practice association responsible for utilization management decisions regarding his health care.[1] After settling before trial with Health Net for nearly $4 million, Larue proceeded to trial against Accountable, recovering a jury verdict exceeding $7 million. The trial court granted Accountable's motion for new trial, and denied its motion for judgment notwithstanding the verdict (JNOV). Larue appeals the new trial; Accountable appeals the denial of JNOV. We modify the grant of a new trial to retain the jury's finding of liability, and otherwise affirm.

FACTUAL AND PROCEDURAL BACKGROUND

Because the principal issues on appeal implicate the sufficiency of the evidence, we provide the factual background in considerable detail.

1. *Larue's Background*

Terry Larue suffered from dyslexia and dropped out of high school. He eventually found his niche as a skateboard videographer. He taught himself how to work with a video camera, and started making money filming skateboarders performing tricks. Unlike other videographers, Larue could video skateboarders while he, himself, was also skateboarding. He

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[1] Accountable's sole shareholder testified that it was an "independent practice association." Its counsel described it as an "independent physicians association." We will simply use the abbreviation, "IPA."

began by selling individual video clips of tricks, and was ultimately hired by Skate One, which paid him a monthly wage to act as a team videographer, going on tour with a skateboard team. At least half of his filming was done tracking a skateboarder while he was also on a skateboard.

2. *Larue Obtains Insurance*

In May 2014, Larue went on a trip with Skate One to Colorado. Just prior to the trip, he purchased health insurance from Health Net via the Covered California website. He obtained a plan called CommunityCare.

Under the terms of his plan, except for emergency care, Larue could obtain coverage for physician and hospital services only when he used a "CommunityCare Network Physician or Hospital." He was required to select a primary care physician from the CommunityCare Network. In addition, he was to select a "Participating Physician Group (PPG)," which was defined as "the Health Net contracting medical group [he] selected as the source of all covered medical care." The plan documents explained, "Except in an emergency or other urgent medical circumstance, the covered services of this plan must be performed by your Physician Group . . . or authorized by them to be performed by others. You may use other providers outside your Physician Group only when you are referred to them by your Physician Group . . . ."

Larue's Physician Group was Accountable; his primary care physician was Dr. Birinder S. Brara. Larue did not have any interaction with Accountable or Dr. Brara prior to his hand injury.

3. *The CommunityCare Relationship Between Health Net and Accountable*

Before we discuss Larue's injury and his attempts to obtain treatment, we first outline the contractual relationship between Health Net and Accountable, as it pertained to the CommunityCare program.

CommunityCare was a new health plan which Health Net developed after the Affordable Care Act came into effect. Health Net had an existing contractual relationship with Accountable, under which Accountable provided health care to a subset of Health Net's enrollees on a capitated basis under other plans.[2] But the creation of CommunityCare required a new agreement with Accountable.

Health Net and Accountable entered into an addendum to their agreement, which was entitled, "CommunityCare Non-Capitated HMO Benefit Program." Under this addendum, Accountable agreed to participate in CommunityCare. It would provide a network of physicians and it would perform certain duties.

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[2] "Capitation payments are made in connection with a risk-sharing arrangement between a health plan and a contracting medical provider under which the provider receives compensation on a 'capitated basis.' ' "[C]apitated basis" ' is defined by regulation to mean 'fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided.' [Citation.]" (*Centinela Freeman Emergency Medical Associates v. Health Net of California, Inc.* (2016) 1 Cal.5th 994, 1004, fn. 8.)

As to the network of physicians, Accountable agreed to provide a network that consisted of at least 80 percent of its existing capitated panel of professional providers – who were themselves either employed by Accountable or had contracted directly with Health Net. In fact, it does not appear that any providers were directly employed by Accountable; it provided medical services through a network of independent contractors. Accountable agreed that, as to those providers who were not employed by Accountable, Accountable would ensure that each provider had a contract with Health Net. Accountable agreed to "manage" and "maintain" the panel, and that it would contain primary care physicians and specialists in a number of identified fields, including, as relevant here, orthopedic surgery. It also agreed to ensure "that a sufficient number and type of Professional Providers" in the panel "maintain staff privileges with at least one hospital participating in CommunityCare. . . ." Although the CommunityCare addendum only required Accountable to provide 80 percent of its network to CommunityCare patients, Accountable chose to provide the same network across all the insurance plans it serviced. The network available to Larue consisted of approximately 450 primary care physicians, some 1700 specialists, and a few hospitals.

As to the duties delegated to it by the CommunityCare addendum, Accountable agreed to perform utilization management for the CommunityCare members who were signed up with its Physician Group.[3] It agreed to comply with Health

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[3] Broadly speaking, utilization management involves using established criteria "to determine whether to authorize, modify, or deny health care services." (Health & Saf. Code, § 1363.5, subd. (b).)

Net policies regarding utilization and care management, including all prior authorization requirements. Specifically, it agreed "to authorize and manage Covered Services at the appropriate level of care." However, Accountable was not obligated, itself, to pay the providers in its panel for the medical care they rendered CommunityCare members; that obligation remained Health Net's, pursuant to the terms of the direct agreements between the providers and Health Net. For this reason, with respect to CommunityCare, Accountable was not acting as a traditional IPA, as IPAs are generally understood to undertake primary responsibility for the provision of health care, including assuming the financial risks and burdens of doing so. (Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2017) ¶ 6:921, p. 6E-39.)

Accountable's obligation to perform utilization management meant that Accountable was responsible to authorize necessary services for CommunityCare members. Pursuant to Health Net's requirements, there were three types of authorizations. First, there were direct referrals, by which a primary care physician could use a form to refer a patient to one of a list of pre-authorized in-network specialists. These required no additional approval by Accountable. Second, there were referrals which required Accountable's pre-approval. The primary care physician would make the referral, and Accountable would have to approve it before the services could be rendered to the patient. Third, there were referrals for which Accountable would have to obtain pre-approval from Health Net in order to authorize the service. Accountable was provided with a list of which services required no preauthorization, those that needed to be preauthorized by only Accountable itself, and those which

required Health Net pre-approval. As relevant to our case, a referral to a provider who was not part of the Accountable network required pre-approval from Health Net.

In preparation to launch CommunityCare with Accountable, Health Net provided Accountable with a PowerPoint presentation setting out how the new plan was going to work. Health Net gave the presentation, via conference call, to some senior officers at Accountable, with the expectation that the information regarding the requirements of the CommunityCare program would be conveyed to others at Accountable. The PowerPoint presentation contained a section on "Referrals & Prior Authorization." It explained that services and referrals for CommunityCare members "must be provided by, or referred to, participating CommunityCare HMO physicians and hospitals." The presentation contained an appendix, listing then-participating hospitals, but noted that providers must access the Health Net website "to find participating CommunityCare HMO providers."[4] The presentation confirmed that Accountable would be responsible to obtain necessary prior authorizations from Health Net, and referred Accountable to an Appendix for a copy of the CommunityCare Prior Authorization requirements. That appendix clarified that referrals to non-participating providers must be approved by Health Net. The regional network director for Health Net who gave the presentation testified that she told

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[4] The list of hospitals in the PowerPoint appendix stated, "This list of Health Net participating CommunityCare HMO hospitals is current as of November 8, 2013. Providers must access ProviderSearch on the Health Net website at provider.healthnet.com to verify continuing CommunityCare HMO participating status."

Accountable that the items for which Accountable was required to obtain prior authorization from Health Net included going out of network.

4. *Larue's Injury and Diagnosis*

In May 2014, Larue and the Skate One team he was filming drove from Los Angeles to Colorado. On Monday, May 5, they were in Denver. Larue was on a skateboard, tracking the skateboarder he was filming, when Larue's skateboard hit a crack. The board stopped underneath him and he continued flying forward. On landing, he slammed his left hand on the ground. When Larue stood up, his hand felt wrong. Someone from the team immediately drove him to the emergency room.

At the emergency room, x-rays were taken of Larue's hand. The physicians diagnosed a Bennett's Fracture of his thumb. They splinted the thumb. Larue was told that the fracture had to be taken care of quickly and he should not hesitate. He was given the name of a surgeon, and was told that he should call the surgeon and set up an appointment to have the surgery the following day.

5. *Two Ways to Treat a Bennett's Fracture*

A Bennett's Fracture is a fracture at the base of the thumb. Larue's Bennett's Fracture was an intra-articular fracture, meaning that it was in the joint where articular cartilage is found. If the joint is not reestablished, a patient may suffer from early degenerative arthritis and its associated pain.

A Bennett's Fracture is, by definition, a displaced fracture. There are two ways to get the bones back into alignment – depending on how quickly a surgeon can address the break. The timing is related to the development of callus. Callus is the formation of bone across the facture area; it is the body's attempt

to heal itself. If callus begins to form over a displaced fracture, it results in a malunion of the bones.

If a surgeon can treat a Bennett's Fracture before sufficient callus has formed, the surgeon can perform a so-called "closed" reduction of the fracture. Under anesthesia, and with the use of a fluoroscope, the surgeon can realign the fracture without incisions, and wire the bones into place, to hold them while the bone heals.

If the Bennett's Fracture is not addressed until substantial callus has formed and a malunion develops, the surgeon must perform an "open" reduction. This requires surgically opening the hand, removing the callus with a medical chisel, and then realigning the bones, so that they will re-heal properly. Generally, closed reduction surgery is preferred.

The small bones in the hand form callus very quickly. If a patient is going to be a candidate for an open reduction, the surgery has to occur within a week or 10 days of the injury. Possibly, depending on the patient, that window can be extended to 14 days.

An open reduction results in a significantly more difficult recovery than a closed one, with greater soft tissue damage and greater resulting stiffness. While a closed reduction does not necessarily mean a better result for the patient than an open reduction, an open reduction is a more severe trauma for the patient. Generally speaking, it is better to repair a fracture as soon as possible. Even if a fracture must be treated with an open reduction, earlier surgery usually translates to greater success. After 14 days, even an open reduction is "a real problem," because there has been so much scar tissue and callus formation.

As we shall discuss, every medical professional who saw Larue believed he needed surgery within the 14-day window. However, this did not occur, for reasons Larue blames on Accountable.

6. *Accountable's Delays Force the 14-Day Window to Expire Without Surgery*

The basis of Larue's cause of action against Accountable was that it delayed in approving his surgery with a qualified specialist until after the 14-day window had elapsed. Detailed review of the evidence shows that while Accountable superficially appeared to timely approve all requests, at least two of its approvals were empty gestures – one was for surgery at an out-of-network hospital not pre-approved by Health Net and one was an untimely referral to an unqualified specialist.

A. *Day 1 – Tuesday, May 6 – Larue Flies Home*

The emergency room in Denver had set Larue up with a surgeon who could have performed the surgery on May 6. This did not happen. The record is not entirely clear as to why; it appears a decision was made that Larue should have the surgery in California so that he would have continuity of treatment. Larue's father believed "there was an issue with insurance in Colorado versus California also."

In any event, Skate One paid to fly Larue home from Denver on May 6. Larue's wife picked him up at the airport.

While he was in the car returning from the airport, Larue called Accountable at the telephone number that was on his insurance card. He told them what had happened. He then tried to call Dr. Brara, his primary care physician, but did not speak to the office.

B. *Day 2 – Wednesday, May 7 – Larue Gets Additional X-Rays*

The following day, May 7, Larue spoke with Dr. Brara's office. Dr. Brara could not see him that day, but told him to get x-rays and bring them in for an appointment on May 8.

Larue promptly obtained another set of x-rays.[5]

C. *Day 3 – Thursday, May 8 – Dr. Brara Makes a Direct Referral to Healthpointe Medical Group*

On May 8, Larue brought his x-rays to Dr. Brara. Dr. Brara agreed that Larue had a Bennett's Fracture which needed to be quickly addressed. Dr. Brara filled out a direct referral to Healthpointe Medical Group, for an orthopedics "Initial Consult/Treatment."

Larue telephoned Healthpointe multiple times that day, but could not get through to anyone.

D. *Day 4 – Friday, May 9 – Larue Cannot Make an Appointment with Healthpointe; Father Calls Health Net*

On May 9, Larue continued calling Healthpointe, but nobody answered.

Larue's father telephoned Health Net, because he believed Larue needed quicker attention than what he was receiving. He was told to fax in the referral Larue had received, and did so. The Larues were told that they would get a telephone call back the following morning at 9:00 a.m.

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[5] The first set had been taken in the Colorado emergency room.

E. *Day 5 – Saturday, May 10 – Larue Goes to the Emergency Room*

When Larue did not receive a call the next morning from either Accountable or Health Net, he called Health Net to follow up. Health Net contacted Accountable and learned that no one at Accountable could provide any information until Monday, May 12. However, if the situation was an emergency, Larue could go to the hospital, where the emergency room could call Accountable's on-call case manager and obtain approval for emergency surgery.

Larue went to Cedars Sinai Hospital, where he was seen by Dr. Ryan Dellamaggiora, an orthopedic hand and sports medicine doctor. Dr. Dellamaggiora agreed that Larue needed surgery "preferentially within the next week." He told Larue to follow up with him if Larue's insurance was unable to find an in-network physician to help him within the next week. Dr. Dellamaggiora's report ends with, "Patient should have urgent surgery of his fracture."

F. *Days 6 & 7 – Sunday and Monday, May 11-12 – More Time Passes; Larue Files a Grievance*

The weekend went by and Larue was no closer to surgery.

On Monday May 12, he had heard nothing regarding an appointment for surgery.

The relationship between Health Net and Accountable was such that any patient grievances were to be directed to Health Net, not Accountable. On May 12, Larue submitted a grievance to Health Net based on the delay. Health Net contacted Accountable regarding the grievance, seeking an expedited response no later than 10:00 a.m. the following morning.

G. *Day 8 – Tuesday, May 13 – Larue Sees Dr. Plut*

At 10:00 a.m. on Tuesday, May 13, Accountable responded to Health Net that Dr. Brara had now made a direct referral to Dr. Plut, and that an appointment with Dr. Plut was scheduled for that day.[6]

Larue was, in fact, seen by Dr. Plut that day. Dr. Plut, an orthopedic surgeon, testified that there is a subspecialty in orthopedics for hand surgery. He has treated hand injuries, but hand surgery is not his specialty. Dr. Plut reviewed Larue's x-rays and concluded that he was not best suited to do the surgery. Larue's injury was not something that he saw frequently, and he knew there were other people who were more qualified to do the surgery. Specifically, he believed Larue needed a hand surgeon. He told Larue to return to his primary care physician and obtain a referral to a hand surgeon who works with his insurance plan.

H. *Day 9 – Wednesday, May 14 – Larue Sees Dr. Weil*

On May 14, Dr. Brara submitted an urgent referral to Dr. David Weil, a hand surgeon at Healthpointe. Accountable approved the referral the same day. Larue had an immediate appointment.

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[6] Dr. Brara's direct referral to Dr. Plut appears to be dated May 8, the same day as his direct referral to Healthpointe. We have reviewed the two referral documents in the appellate record and the handwritten information at the top of the forms (patient information, referring provider, and date) appears to be exactly the same, as though someone photocopied the referral to Healthpointe and simply changed the destination of the referral (on the bottom portion) from Healthpointe to Dr. Plut. For this reason, we cannot be certain of the date on which Dr. Brara referred Larue to Dr. Plut.

Dr. Weil did not testify at trial; we only know what happened with Dr. Weil through written exhibits and Larue's recollection. Dr. Weil's Evaluation/Progress notes from the May 14, 2014, appointment show, under the heading, "Plan," the following: "Closed versus open reduction internal fixation in operating room. [¶] RTC 5/22[7] [¶] We may not be contracted with his insurance at any of the places I operate [¶] Request office visit, x-ray, and splint if not approve on SX[8]" (Capitalization omitted.)

Larue testified that Dr. Weil told him, at the May 14 appointment, that he could not do the surgery because he was not contracted with a hospital within the CommunityCare network.

Nonetheless, Dr. Weil's records show that, the very next day, Dr. Weil sought approval for the surgery.

I. *Day 10 – Thursday, May 15 – Dr. Weil Seeks Out-Of-Network Approval*

On May 15, Dr. Weil submitted a request to Accountable for prior authorization for surgery at Tri-City Regional Hospital. He sought approval for an outpatient procedure, identified as "Closed versus open reduction internal fixation L thumb." We note that, since this was an outpatient procedure, it did not require Health Net pre-approval as an inpatient hospitalization. However, it did require Health Net pre-approval because Tri-City was not in Accountable's network.[9]

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[7] This is an apparent reference to a follow-up appointment.

[8] This is an apparent reference to surgery.

[9] In its respondent's brief on appeal, Accountable states that although Tri-City was not in the CommunityCare network, it

The documents indicate that Accountable approved the request that very day, well within the 14-day window. However, the approval would not be transmitted to anyone for some time. Moreover, Accountable did not obtain, or even seek, Health Net's approval for the out-of-network hospital.

J. *Day 11 – Friday, May 16 – Dr. Brara Seeks Approval for an In-Network Hand Surgeon*

On May 16, 2014 – Day 11 – Dr. Brara submitted to Accountable a request for approval of a referral. Dr. Brara did not identify any specific doctor to whom he wanted to refer Larue; instead, in the space for the doctor's name and address, Dr. Brara wrote: "Hand surgeon that will do surgery w/contracted hospital." In the line for "Specialty," Dr. Brara again wrote, "Hand surgeon." Under "Clinical Information," Dr. Brara wrote,

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"was in the Health Net network." The testimony cited does not support such an unambiguous statement. Instead, it establishes that Tri-City was *not* contracted with Health Net, although, for a time, Accountable was of the belief that it was. Because it appears so frequently in Accountable's briefing, we must underline the point. Accountable's witness testified that Accountable learned, on May 28, that Tri-City was not contracted with Health Net. Although the witness also gave some testimony suggesting that Accountable had "opposite information" prior to that point, the vague reference to "opposite information" cannot support Accountable's representations that it was *undisputed* that Dr. Weil had privileges at a Health Net-contracted hospital. Indeed, it appears most likely that Tri-City was never contracted with Health Net, and Accountable was simply mistaken. Accountable may have even confused Tri-City Regional Hospital with a different hospital also named Tri-City, one that was in the Health Net network.

"patient has seen a hand surgeon for his fracture Dr. Weil but he isn't contracted with any of the places where he operates at. Please [unintelligible] and approve ASAP." Dr. Brara checked the box marking the request as "Urgent" and wrote "URGENT STAT" on the top of the form.[10]

K. *Days 12-14 – Saturday May 17 to Monday May 19 – the 14-Day Window Closes With No Action on the Referral Request*

By statute, a request for an urgent referral must be resolved within 72 hours, and the result issued to the provider within 24 hours following the authorization. (Health & Saf. Code, § 1367.01, subd. (h)(2), (3).) Accountable's documentation indicates that it made a referral to Dr. Charles Alexander, in response to Dr. Brara's urgent May 16 request, that same day. However, nobody at Accountable communicated the approval to anyone until May 20. This four-day delay in communicating the approval meant that the 14-day window in which a closed

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[10] Exhibit 573 consists of Accountable's supplemental document production of utilization management and grievance documents. At trial, the document was *not* admitted into evidence. However, in support of Larue's opposition to Accountable's new trial motion, Larue's counsel submitted a declaration attaching the exhibit and representing it had been admitted into evidence. At no time did Accountable challenge this representation. To the extent the parties treated the document as admitted in evidence, we observe that it includes a chronology which states that, on May 16, "Internal notes indicate 'PER DR. WEIL TRI-CITY IS NOT CONTRACTED WITH HCC. ASK TO RE-DIRECT THE PATIENT TO ANOTHER HAND SURGEON."

reduction might still have been possible for Larue closed while Accountable failed to timely convey its approval.

At trial, Accountable's witnesses testified that the paperwork was wrong, and that the approval itself was actually not made until May 20. But, as Larue points out, even more troubling is the fact that Dr. Alexander, the most recent referral, was not a hand surgeon, and could not do the requested procedure. Initially, Accountable had planned to respond to Dr. Brara's urgent referral request by approving a referral to Dr. Dwight Roberson, a hand surgeon. However, Accountable was not able to "get ahold" of him. Accountable changed the referral to Dr. Alexander.

Dr. Alexander was a general orthopedic surgeon, and did not hold himself out as a hand specialist. According to Accountable, before it made the referral, it verified with Dr. Alexander's office that he could perform the procedure Larue needed. According to Dr. Alexander, the only hand fractures he handles are the "fairly simple, straightforward" ones. Dr. Alexander testified that no one from Accountable called his office to ask whether he would treat someone with a Bennett's Fracture almost four weeks post-fracture.[11] Dr. Alexander said that if his office had received that call, the question would have come to his attention, and his response would have been, " 'He needs to see a hand surgeon.' " Accountable states on appeal that Dr. Alexander's office had "confirmed to Accountable before the

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[11] The referral was actually made when Larue was approximately two weeks post-fracture. The discrepancy appears to have arisen because Dr. Alexander would not actually see Larue for another week.

referral that he could perform the necessary procedure." On the contrary, Dr. Alexander's testimony supports the inference that Accountable never called his office to verify whether Dr. Alexander was qualified to perform the surgery.

7. After the 14-Day Window Closed, Larue's Surgery is Delayed an Additional Month Wasting Time on Dr. Alexander and Dr. Weil

After the 14-day window closed, sufficient callus had formed such that not only was a closed reduction no longer possible, even an open reduction would be a difficult surgery. Larue's surgery was further delayed by the four additional weeks it took to confirm that Dr. Alexander could not do the surgery and Dr. Weil was not approved to do the surgery at Tri-City.

A. *Accountable Simultaneously Approves Surgery With Dr. Alexander and Suggests Surgery With Dr. Weil May Still be Possible*

On May 20, Accountable sent its approval of surgery with Dr. Alexander to Dr. Brara, and told Dr. Brara to contact Larue and assist him in setting up the appointment. As it turns out, Dr. Alexander would not see Larue until May 27.

On the same day Accountable transmitted its approval of the self-unqualified Dr. Alexander (May 20), Larue was led to believe that surgery with the qualified-but-not-affiliated-with-a-network-hospital Dr. Weil was still a possibility. Larue's wife had called Health Net trying to get an update on Larue's request for surgery. Health Net spoke with Accountable, and the upshot of it was that Larue's wife was informed of the *prior May 14* authorization for surgery with Dr. Weil, not the current authorization for surgery with Dr. Alexander. Larue's wife was told to call Dr. Weil's office to schedule the surgery, but was

advised that Tri-City would need to contact Health Net to verify surgery benefits. The next day, Accountable faxed to Dr. Brara its previous approval of surgery with Dr. Weil at Tri-City.

B. *Surgery with Dr. Weil Does Not Proceed at Tri-City*

Dr. Weil never performed surgery on Larue. His records include a single-page form, apparently filled out on May 23, 2014, by someone in his office named Debbie (not otherwise identified), which sheds some light on why Dr. Weil did not, in fact, perform the surgery at Tri-City, despite Accountable's approval. The form is a Healthpointe Medical Group "Surgery Verification Form." The purpose of the form is apparently to confirm insurance coverage and benefits for any planned surgery.[12] Where the form asks for the patient's insurance, Debbie wrote "Health Net – Covered Calif." Where the form asks the type of plan, whether PPO, HMO, Medicare, or something else, Debbie has written in "IPA-MEDI-CAL." Across the middle section of the form, where "In Network" and "Out of Network" benefits are to be listed, Debbie wrote, across the entire section, "IPA-MED-CAL" and "UNABLE TO PROVIDE." The form has a box where the person filling out the form is to document whom she "Spoke with"; Debbie wrote "UM Dept," an apparent reference to utilization management.

Accountable took the position at trial that this document demonstrated that the surgery was declined at Tri-City because "a hospital staff person mistakenly believe[d Larue was] a Medi-Cal patient." The record indicates otherwise: it was not a hospital staff person, but Debbie, from Dr. Weil's practice group,

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[12] Accountable's witness agreed that a hospital will not schedule surgery unless it has verification of coverage.

who had that belief. More importantly, though, was that Debbie apparently obtained this information from the "UM Dept." She did not identify, however, whether the "UM Dept" who gave her this information was at Health Net or Accountable.[13]

C. *Dr. Alexander Declines the Surgery*

With Dr. Weil unable to perform the surgery at Tri-City, Accountable's approval of surgery with Dr. Alexander came back into play. But Dr. Alexander was a general orthopedic surgeon only, and was not willing to perform the complex surgery for which Larue needed a hand surgeon. The Discussion/Plan section of the notes from Dr. Alexander's May 27 new patient evaluation reads: "This is already four weeks post fracture. His callus is probably significantly firm, and he would require taking down that callus and having internal fixation. This needs to be done as quickly as possible. He should be seen by a hand surgeon. This is not going to be an easy reduction. I put in a call to Health Net. We are in some kind of a general mailbox only. We left a message for them to call us back. I want to speak to

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[13] We note here that Accountable's position at trial was that because it had authorized Dr. Weil to perform Larue's surgery at Tri-City, Dr. Weil and Tri-City would have been paid by Health Net for that surgery. If that were so, the record does not disclose why Dr. Weil chose not to proceed. In contrast, the Health Net representative who testified at trial did not state that Health Net would have paid for the surgery at an out-of-network hospital based on Accountable's sole approval. Instead, the witness testified that whether Health Net compensates the hospital depends on whether it has a letter of agreement in place with the hospital. The witness underlined that this was why Health Net imposed its own preauthorization requirements for out-of-network hospitals.

someone and see if we can expedite his referral quickly." Neither Health Net nor Accountable returned Dr. Alexander's call.

8. *Larue Finally Undergoes Surgery with Dr. Roberson, a Hand Surgeon, on June 19*

On May 28, Larue had a follow-up appointment with Dr. Weil. Dr. Weil requested Larue's referral to hand specialist Dr. Roberson. This was approved. By the time Dr. Roberson saw Larue, it was approximately one month after his injury, and Dr. Roberson concluded this was "now a chronic Bennett's fracture. Because of the delayed treatment, the fracture will require open reduction and pinning." Dr. Roberson told Larue there would likely be residual stiffness and decreased range of motion because of the delay in treatment.

Surgery was performed on June 19, the first available date Dr. Roberson had in coordination with the in-network hospital. By this time, it was seven weeks after the fracture had occurred; Dr. Roberson's surgical notes indicate that the "fracture site was partially healed and consolidated in a malposition." Dr. Roberson testified that he was required to "make an incision through the skin, remove the muscles around the fracture site, open the fracture site. And at that time the fracture site had healed. It was a hard callus around the fracture site. So I had to re-break it using an osteotome and mallet, or essentially, a chisel and hammer, to break the hard bone from around the fracture site. [¶] And once that had been completed, then had to realign the two fractured ends in the – as close as possible to the anatomic position. And then after that, once I got that in that position, then place a pin through the bones to hold those two pieces together."

Dr. Roberson testified that if he had been called the day after the fracture about a member with a Bennett's Fracture, he would have scheduled a visit. If the x-rays confirmed the fracture was displaced out of alignment, he would have done everything he could to schedule a procedure – either closed or open – within 10 days to two weeks of the fracture.

9. *Larue Develops Complex Regional Pain Syndrome*

The surgery did not put an end to Larue's problems. Six weeks after the surgery, Dr. Roberson removed the pins and determined Larue's hand was now healing properly. However, Larue continued to have pain.

The pain in Larue's hand did not dissipate over time. It increased. His hand was blistering, sweating, and discolored. Larue initially did not seek medical intervention for the pain, because he had been told that the delay in surgery would result in residual discomfort and limited range of motion. However, his pain became so extreme that he eventually realized his symptoms went beyond typical post-surgical pain.

In December 2015, some 18 months after the surgery, Larue was diagnosed with Complex Regional Pain Syndrome (CRPS). Medical science does not yet know what causes CRPS. A defense expert explained, "We think that the nerves are wound up and they're overexcited, and it manifests in what we call a syndrome." Its symptoms include excruciating pain, hypersensitivity, and changes in blood flow which result in changes in color and temperature.

The pain from CRPS is extreme and disabling; the pain, emotional distress, and inability to work resulting from CRPS were the basis for the vast bulk of the damages Larue sought and

obtained at trial.[14] Accountable did not challenge the diagnosis of CRPS; it agreed that Larue was, in fact, suffering from CRPS. However, it took the position that the CRPS was not caused by any delay in treating Larue's Bennett's Fracture. We therefore turn our discussion not to the ways in which CRPS impacted Larue's life, but the conflicting expert opinions as to whether the delay in treatment was a cause of it.

CRPS is triggered by the body's overreaction to an insult to the area; it can be large (like surgery) or small (like bumping against a table). The issue, however, is one of timing. Even plaintiff's expert, Dr. Joshua Prager, agreed that CRPS generally manifests within weeks of the triggering incident. But Dr. Prager took the position that Larue had, in fact, been suffering some of the early symptoms of CRPS even before Dr. Roberson removed the pins six weeks after surgery – when Larue thought he was simply suffering the expected post-surgical pain. Dr. Prager testified that there was no evidence of any other precipitating incident, and he believed that the objective evidence of Larue's symptoms showed that his CRPS was simply "smoldering" during this time, and fully manifested later. He opined "beyond" a reasonable degree of medical certainty that the delay in treatment, which required an extensive surgical procedure, was the cause of Larue's CRPS. In fact, he testified that it was a more likely cause than the fracture itself.

In contrast, Accountable relied on the testimony of two experts, Dr. David Fish and Dr. George Macer, each of whom testified that the lapse of time between the surgery and the onset of CRPS symptoms excluded the delayed surgery as a cause.

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[14] Larue could no longer film while riding a skateboard, the skill that had set him apart from other videographers.

Although they could not point to another triggering incident with any degree of certainty, they noted that the insult which causes CRPS need not be particularly significant or memorable.

10. *The Lawsuit and Its Resolution*

On December 9, 2014, prior to Larue's CRPS diagnosis, Larue brought suit against Health Net and Accountable for damages arising from the delay in his treatment. The operative complaint added his primary care physician, Dr. Brara, and a cause of action alleging medical negligence against him for not providing proper, timely referrals.

On the eve of trial, Larue settled with Health Net for $3,950,000, and with Dr. Brara for $100,000.

The action proceeded to a jury trial against Accountable alone on two causes of action: negligence and violation of Civil Code section 3428 – a statute which provides a cause of action when a "health care service plan" fails to exercise "ordinary care" to arrange for medically necessary health care services and that failure results in substantial harm to the enrollee.[15]

At trial, Larue proceeded on a theory that Accountable's delay in authorizing surgery resulted in his CRPS and, therefore, substantial damages. He particularly focused on Accountable's so-called approval of Dr. Weil to perform the surgery, which was useless without Health Net preauthorization because Dr. Weil did not have privileges at a CommunityCare hospital. He also argued that Accountable did not have sufficient hand surgeons in its network, given that Dr. Roberson was the *only* hand surgeon in Accountable's network with privileges at an in-network hospital. In response, Accountable took the position that it "said

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[15] We discuss the specific language of Civil Code section 3428 in Part 3 of our Discussion.

yes" to every referral request submitted to it, and, further, that Larue did not establish that any delay caused his CRPS.

The jury returned a verdict for Larue, concluding that Accountable was negligent and had violated Civil Code section 3428. During deliberations, the jury had submitted a question asking if damages under Civil Code section 3428 are the same as negligence damages, or if they should be a different award in addition to the negligence damages. The trial court instructed the jury that the amount was the same, and the jury awarded the same damages for each cause of action. Larue's damages were calculated as $3,225,000 in economic damages (consisting of $2,500,000 in future medical costs and $725,000 in loss of future earning capacity) and $4 million in non-economic damages ($2 million for pain and suffering and $2 million for emotional distress), for a total award of $7,225,000.[16] In its special verdicts, the jury concluded that neither Dr. Brara nor Health Net was negligent and that, instead, Accountable was 100 percent responsible for Larue's harm.

11. *Posttrial Motions*

Accountable moved for a new trial and judgment notwithstanding the verdict.[17] The new trial motion argued the

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[16] Earlier, the trial court had granted a nonsuit on Larue's claim for punitive damages. Larue appeals this ruling only "if the new trial order is reversed in full." Because we affirm the new trial order in part, we treat this argument as withdrawn.

[17] A third posttrial motion was brought by Larue, who sought to allocate the pretrial settlements between economic and non-economic damages in the same percentages as the jury verdict, for the purposes of offset. As we will affirm the trial court's grant

verdict was against the weight of the evidence, and that damages were excessive. The JNOV motion argued that the negligence verdict could not be allowed to stand as Larue introduced no expert testimony that Accountable had violated the standard of care of an IPA. It further argued that the Civil Code section 3428 verdict could not stand because Accountable, as an IPA, was not a "health care service plan" within the meaning of the statute.

The trial court denied JNOV, concluding that, as this was a case involving delayed treatment, expert testimony was not required. It did, however, grant a new trial.

The court's order granting a new trial identified multiple grounds; but they fall into two general categories: the weight of the evidence does not support the jury's findings; and the damages awarded were excessive. As to the first, the trial court concluded the weight of the evidence was against the jury's express or implied findings of (1) Accountable's breach of duty; (2) apportionment of fault (100% to Accountable); and (3) causation of CRPS. Because we agree that the new trial was properly granted with respect to apportionment and causation, we need not address the trial court's grant of a new trial for excessive damages.

12. *Appeal*

Larue appealed the order granting a new trial. Accountable appealed from the denial of the JNOV and included a protective cross-appeal from the judgment.

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of a new trial on damages, we need not address the trial court's ruling on the settlement allocation motion.

DISCUSSION

We first address, and reject, Accountable's argument that it was entitled to JNOV on the basis that Larue failed to present expert testimony on the issue of duty of care. We then turn to Larue's argument that the trial court's grant of a new trial is unsupported, and conclude the new trial was properly granted as to apportionment and causation (and therefore damages) but must be reversed as to liability. Finally, we close with a discussion of Accountable's argument that it was entitled to partial JNOV, on Larue's Civil Code section 3428 cause of action.

1. *JNOV Was Properly Denied on Negligence*

A. *Standard of Review*

"On appeal from the denial of a JNOV motion, an appellate court must review the record de novo and make an independent determination whether there is any substantial evidence to support the jury's findings. [Citations.] This review is limited to determining whether there is any substantial evidence to support the jury's verdict. [Citation.] The court must accept as true the evidence supporting the verdict, disregard conflicting evidence, and indulge every legitimate inference to support the verdict. [Citation.] If sufficient evidence supports the verdict, a reviewing court must uphold the court's denial of the JNOV motion. [Citation.] If the appellant raises purely legal questions, we conduct a de novo review. [Citations.]" (*Hirst v. City of Oceanside* (2015) 236 Cal.App.4th 774, 782.) Here, Accountable raises only an issue of law; our review is therefore de novo.

B. *Expert Testimony Was Not Required*

Accountable argues that the verdict cannot stand because Larue was required, and failed, to establish the elements of duty of care and breach with expert testimony.

" '[N]egligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm.' [Citation.] Thus, as a general proposition one 'is required to exercise the care that a person of ordinary prudence would exercise under the circumstances.' [Citations.] Because application of this principle is inherently situational, the amount of care deemed reasonable in any particular case will vary, while at the same time the standard of conduct itself remains constant, i.e., due care commensurate with the risk posed by the conduct taking into consideration all relevant circumstances. [Citations.]" (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997, footnote omitted.)

"With respect to professionals, their specialized education and training do not serve to impose an increased duty of care but rather are considered additional 'circumstances' relevant to an overall assessment of what constitutes 'ordinary prudence' in a particular situation. Thus, the standard for professionals is articulated in terms of exercising 'the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing . . . .' [Citation.]" (*Flowers, supra,* 8 Cal.4th at pp. 997-998.)

In negligence cases arising out of the rendering of professional services, the standard of care is a matter peculiarly within the knowledge of experts, and expert testimony is therefore generally required to establish the standard. (*Flowers, supra*, 8 Cal.4th at p. 1001.) However, expert testimony is not required when the conduct required by the particular circumstances is within the common knowledge of laypersons. (*Ibid.*) Although this common knowledge exception most often

arises in cases of res ipsa loquitur, it is not limited to those cases. (*Ibid.*) Indeed, the *Flowers* case itself involved a plaintiff who fell off a hospital gurney and alleged the nurses and hospital were negligent in not raising the railings on the gurney. The California Supreme Court remanded the matter to the Court of Appeal to decide in the first instance whether the standard of care in that case could be established without expert testimony. (*Id*. at pp. 995, 1001-1002, & fn. 5.)

We understand that, although this case involves Larue's claims of delayed medical treatment, Larue does not assert that Accountable breached a *medical* standard of care. The main negligent act on which Larue relied – purporting to approve Dr. Weil to perform surgery at Tri-City without obtaining Health Net's preauthorization of the out-of-network hospital – was not a medical decision in any way. In fact, none of Accountable's acts and failures to act were represented to be medical decisions based on Larue's medical needs. (See Health & Saf. Code, § 1374.30 [creating an independent medical review system for review of adverse utilization management decisions based on determinations of medical necessity, but not those based on coverage].) Thus, Larue's negligence cause of action against Accountable does not implicate questions of how a reasonable medical practitioner should act, but, rather, the acts required of a reasonable IPA or other entity involved in utilization management decisions.[18]

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[18] Accountable argues that "[i]ssues of medical treatment, appropriate clinical evaluation, current and future medical conditions, and escalation of clinical decisions embrace professional issues of clinical medicine. [Citation.]" This may be true, but is beside the point. Failing to obtain Health Net's

The parties do not rely on, and independent research has not disclosed, any California authority specifically governing whether such non-medical decisions require expert testimony or fall within the common knowledge exception.[19] When there are

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preauthorization of Tri-City did not involve an issue of clinical medicine; it simply involved an administrative foul-up.

[19] We requested additional briefing on the issue post-argument. Accountable relied on *Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 285-286, as a case which "affirmed a directed verdict in an administrative negligence case based on the absence of expert testimony." We disagree with this characterization of *Osborn*. The case involved the death of a child, who had contracted the AIDS virus from a blood transfusion. The child's parents sued both the blood bank and the university hospital where the surgery had been performed. At the time of the child's surgery, there was no known test to screen donor blood for the AIDS virus; the plaintiffs proceeded on the theory that the blood bank should have tested for hepatitis B antibodies as a surrogate for AIDS testing. As against the blood bank, the case involved expert testimony as to the state of the scientific knowledge at the time and whether the standard of practice in blood banks required use of the hepatitis B antibody test as a weak proxy for a non-existent AIDS test. (*Id*. at pp. 246-271.) There is no question that the type of screening a blood bank was required to do is a matter for expert testimony. As against the hospital, the plaintiffs had argued that it was negligent both for not doing the same hepatitis B antibody screening and for using the blood bank as its sole blood supplier. The trial court granted a directed verdict for the hospital on the basis that plaintiffs elicited no expert testimony, and the Court of Appeal affirmed, stating, "The merits of the University's policies for blood testing and procurement were issues of professional negligence. A hospital is required to exercise the degree of care,

no California cases, California courts have obtained guidance from out of state authorities. (See *Allgoewer v. City of Tracy* (2012) 207 Cal.App.4th 755, 763 [looking to other states on whether a determination of excessive force falls within common knowledge exception].)

Several state and federal courts which have considered the issue have concluded that expert testimony is not required when the allegedly negligent act is an *administrative*, rather than a medical, decision. (See, e.g., *Pearce v. Feinstein* (W.D.N.Y. 1990) 754 F.Supp. 308, 310 [hospital procedures for responding to manufacturer's recall of catheters administrative]; *McGraw v. St. Joseph's Hosp.* (W.Va. 1997) 488 S.E.2d 389, 396 & cases cited [hospital patient's fall out of bed was due to administrative failure]; *Mills v. Angel* (Tex.Ct.App. 1999) 995 S.W.2d 262, 268 [stating the rule, but finding hospital credentialing and supervision of doctors requires expert testimony].)

Perhaps most persuasive is *Aramyan v. United States* (C.D. Cal. 2010) 2010 WL 532536, a case in which the family of a deceased patient brought a claim of negligence against a community health care center, asserting, among other things, that the center was negligent by not having in place procedures to facilitate urgent surgery once it had received an authorization

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skill and diligence used by other hospitals in similar circumstances. [Citations.] The feasibility of routine [hepatitis B antibody] testing at a hospital, and the relationship between hospitals and blood banks, are not matters of common knowledge. Expert testimony was therefore needed to support the claims of negligence in these areas. [Citations.]" (*Id*. at pp. 285-286.) We agree with the holding in *Osborn*: a hospital's decisions on donor blood screening and blood bank choice are, in this context, medical decisions. Accountable's conduct was not.

for the surgery from the patient's IPA. (*Id.* at pp. *3, *21.) The center argued that this theory had to be supported by expert testimony. In her ruling, District Judge Margaret M. Morrow found the claim fell within the common knowledge exception. (*Id.* at p. *21.) "Here, however, the alleged breach regarding receipt of the authorization was essentially administrative in nature. That is, the breach consisted of the failure to implement procedures to ensure that the document was given to someone who could appreciate its potential significance and respond appropriately." (*Id.* at p. *22.) The court then concluded, "Conceivably, appropriate administrative procedures are within the common knowledge of a lay factfinder. Although the court has not encountered a California case expressing this concept, numerous courts in other states have held that '[t]he standard of nonmedical, administrative, ministerial, or routine care in a hospital need not be established by expert testimony because the jury is competent from its own experience to determine and apply such a reasonable-care standard.' [Citations.]" (*Id.* at p. *22.)[20]

Although the cases speak in terms of an "administrative" decision, we believe another, perhaps more applicable, way of looking at the distinction is that expert testimony is not required when the allegedly negligent act is a non-discretionary *implementation* of a medical professional's expert decision. Thus, when a plaintiff was referred from a hospital to a nursing home with orders that she be restrained at all times, and fell because she was not restrained, no expert testimony was necessary in her suit against the nursing home. (*Tousignant v. St. Louis County*

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[20] *Aramyan* is an non-published federal case which we may cite. (*Western Heritage Ins. Co. v. Frances Todd, Inc.* (2019) 33 Cal.App.5th 976, 989, fn. 6.)

(Minn. 2000) 615 N.W.2d 53, 55-56, 59-60 ["The evaluation of whether the [nursing home] staff complied with those instructions is not a question involving complex scientific or technological issues and is within the general knowledge and experience of lay persons."].) But when a plaintiff fell in a hospital's respite care program, and sued the hospital for not *determining* that he needed greater restraints, this was a medical decision which required expert testimony. (*Kolanowski v. Illinois Valley Community Hospital* (Ill.App.Ct. 1989) 544 N.E.2d 821, 823-824.)

We believe this is a case that falls within the common knowledge, administrative, or implementation exception. It does not take an expert to know that, when an IPA's contract with Health Net requires Health Net to preauthorize an out-of-network hospital, the IPA's purported approval of an out-of-network hospital without Health Net's preauthorization is unreasonable. Similarly, it does not take an expert to know that, when the patient's primary care physician requests an urgent referral to a hand surgeon, a delayed approval of a general orthopedic surgeon who could not do the surgery (and would have said so if asked), is similarly outside the standard of care.

Accountable counters that this case involves "complex management issues," and implicates questions regarding whether the CommunityCare network included Health Net providers in other networks, and whether Accountable could make CommunityCare referrals to such providers without Health Net preauthorization. We disagree. Whether Accountable could make referrals to out-of-network providers was simply a matter of contract interpretation; there was no need for expert testimony on the meaning of the CommunityCare addendum between

Health Net and Accountable. Nor were there any complex management issues implicated by this case. The terms of the CommunityCare arrangement between Health Net and Accountable were set forth in a PowerPoint presentation which was conveyed to Accountable in a conference call. There was no testimony that Accountable's employees charged with implementing CommunityCare had such specialized training or education that their utilization management decisions in this case were professional decisions implicating a professional standard of care; they simply had to read the PowerPoint and follow its instructions.[21]

Accountable argues that, since Larue cannot proceed on the basis of res ipsa loquitur, the common knowledge exception does not apply. First, as we have noted, although the common knowledge exception most often arises in cases of res ipsa loquitur, it is not so strictly limited. (See, e.g., *Mast v. Magpusao* (1986) 180 Cal.App.3d 775, 779-781 [common knowledge exception applies to nursing home resident's claim the staff failed

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[21] We agree that expert testimony is required on one of Larue's theories: that Accountable was negligent by not having a sufficient number of hand surgeons in its network given the number of patients for which it was responsible. Without expert testimony on the requisite number of hand surgeons per patient population, the jury was unable to determine whether Accountable met the standard. (Cf. *Jones v. Chicago HMO* (Ill. 2000) 730 N.E.2d 1119, 1125, 1132 [as to plaintiff's claim that 6000 was too many patients for plaintiff's child's pediatrician, plaintiff need not present expert testimony because the HMO's medical director testified to government guidelines limiting the patient load to 3,500].) We need not address the issue further, however, as we conclude Accountable's liability was established as a matter of law due to its faulty approval of surgery.

to protect her from another resident who was known to be aggressive toward her; no discussion of res ipsa loquitur].) Second, Accountable states that res ipsa loquitur is "utterly inapplicable here, because it certainly is not common knowledge that a two-week delay in surgery for a broken thumb would cause a patient to develop CRPS 18 months later." But this argument goes to *causation*, and Larue presented expert testimony on the issue of causation. We concur with Larue that it is within common knowledge that, when every single medical professional is in agreement that the patient needs surgery within two weeks, an administrative failure to effectively approve the surgery within two weeks is below the standard of care for a utilization management provider. The trial court therefore did not err in denying Accountable's motion for JNOV on the theory that expert testimony was required as to standard of care.

2. *The Grant of a New Trial Must Be Modified to a Partial New Trial on All Issues Except Liability*

Having upheld the negligence judgment against Accountable's JNOV argument, we turn to Larue's appeal of the trial court's grant of a new trial.

A. *Standard of Review*

A court granting a new trial motion must specify both the statutory grounds on which the motion is granted and the court's reasons for granting the motion on each of those grounds. (*Bell v. Bayerische Motoren Werke Aktiengesellschaft* (2010) 181 Cal.App.4th 1108, 1121 & fn. 4.) An order granting a new trial on the ground of insufficiency of the evidence may be affirmed only for the reasons specified in the order. (*Id.* at p. 1121.)

" ' "Review is limited to the inquiry whether there was any support for the trial judge's ruling, and the order will be reversed only on a strong affirmative showing of abuse of discretion. [Citations.]" [Citation.]' [Citation.] [¶] Otherwise stated, an order granting a new trial will not be disturbed if it adequately refers to evidence in the record to support the action taken." (*Romero v. Riggs* (1994) 24 Cal.App.4th 117, 122.)

"[A]n order granting a new trial on the ground of insufficiency of the evidence or excessive damages may be reversed only when 'it can be said as a matter of law that there is no substantial evidence to support a contrary judgment' or to support the trial court's specification of reasons. [Citation.]" (*Thompson v. John Strona & Sons* (1970) 5 Cal.App.3d 705, 709.) This is so even if some of the court's reasons supporting the order were without substantial support in the record. As long as any one reason is adequately supported, the new trial must be affirmed. (*People ex rel. Dept. Pub. Wks. v. Peninsula Enterprises, Inc.* (1979) 91 Cal.App.3d 332, 349.)

As we discuss in the ensuring sections, we conclude that the trial court's new trial order as to causation is well-supported by the record. This requires, at a minimum, a new trial on causation and damages. Turning to liability, we agree that the trial court's new trial order is supported on the issue of apportionment of liability. However, we disagree that the new trial order is supported on the issue of Accountable's liability. In light of this conclusion, we believe the proper disposition on appeal is to order a new trial on all issues except liability; on retrial, the jury must be instructed to find that Accountable is at least one percent liable.

B. *The New Trial Order as to Causation Must Be Affirmed Based on the Trial Court's Reweighing of the Evidence*

One of the grounds on which the trial court based its order granting a new trial was that the weight of the evidence did not support the jury's implied finding that Accountable's negligence caused Larue's CRPS. In giving its reasons for that ground, the court relied on the unanimous testimony of multiple physicians that CRPS cannot be caused by a trigger occurring more than a year prior to its onset. In fact, the court noted that even Larue's expert, Dr. Prager, testified that CRPS ordinarily manifests within weeks of the trigger event.

The court recognized that Larue had relied on the testimony of Dr. Prager that Larue's CRPS was, in fact, caused (during the usual incubation period) by the delay in treating his Bennett's Fracture. Dr. Prager opined the CRPS was simply " 'smoldering' " until the symptoms manifested in full, more than a year later. The court discounted this testimony, however, as being speculative, and contradicted by evidence that Larue did not have any of the symptoms of CRPS during the time Dr. Prager believed the CRPS was smoldering.

The court's reasons are supported in the record. Dr. Prager testified to his opinion that the CRPS symptoms began developing after the surgery and before the pin removal – which would have been in July of 2014. But Dr. Roberson conducted regular post-operative visits with Larue every six weeks through mid-December 2014, and (according to defense expert Dr. Macer) nothing in Dr. Roberson's medical records suggested Larue had any symptoms of CRPS during this time. Dr. Roberson did not disagree, testifying that Larue had been progressing normally,

with no complications. Indeed, even Larue himself testified that he did not have CRPS while he was seeing Dr. Roberson in late 2014, stating that he had localized pain that had diminished as his thumb was healing.

Not only is there evidence that Larue did not have CRPS prior to the end of 2014, there is some evidence that he did not have it until October 2015. Defense expert Dr. Fish reviewed Larue's videotaped deposition from August 2015, and testified that Larue neither articulated any symptoms of CRPS nor showed any signs of it at that time. In contrast, Larue seemed different in his December 2016 deposition, and could have been manifesting CRPS then. At that deposition, Larue testified that there had been a change in his pain in October 2015. Larue did not see a physician about his pain until December 2015.

We, of course, do not re-weigh the evidence, nor do we judge the effectiveness of experts on the two sides. We do assess whether there is substantial evidence supporting the trial court's conclusion that the weight of the evidence did not support the jury's finding that the delay in surgery caused the CRPS. Substantial evidence does exist and the trial court's order granting a new trial on this issue must therefore be upheld.

Larue argues that there should only be a partial new trial, on damages. For this reason, we next consider the trial court's grant of a new trial on liability.

C. *The New Trial Order as to Liability is Supported on Apportionment, but Unsupported on Accountable's Liability*

The trial court's order granting a new trial as to liability encompassed two issues, the jury's failure to apportion any fault

to Health Net and/or Dr. Brara, and the jury's finding that Accountable was itself liable. We consider the issues separately.

(1) *Apportionment*

The trial court concluded that the jury should have allocated some fault to Dr. Brara, as Larue's primary care physician. The court noted that Dr. Brara made an initial referral to (hand surgeon) Dr. Weil (at Healthpointe) but when Larue had difficulty reaching Dr. Weil, Dr. Brara simply made another referral to Dr. Plut (not a hand surgeon) without contacting Dr. Weil directly. The court concluded that, to the extent the referral to Dr. Plut was negligent, Dr. Brara made that referral on his own, with no input from Accountable. This is supported by some evidence.

Similarly, there is some evidence that Health Net was responsible for the delay in surgery, and may well have been the entity responsible for Dr. Weil's refusal to perform the surgery at Tri-City. On May 20, 2014, Larue's wife called *Health Net* which told her the surgery had been approved. She was told to call Dr. Weil's office to schedule the surgery, but was advised that Tri-City would need to contact *Health Net* to verify surgery benefits. On May 23, Debbie at Healthpointe filled out a Surgery Verification Form identifying Larue's insurance as *Health Net* and indicating that she obtained her information from the "UM Dept." And it was this form which falsely identified Larue as a MediCal patient and may have resulted in the surgery denial. The trial court's inference that it was Health Net, and not Accountable, which ultimately made this critical error, is a reasonable one, and supports the trial court's conclusion that the weight of the evidence did not support Health Net's complete

exoneration and the jury's assignment of 100 percent liability to Accountable.[22]

(2) *Liability of Accountable*

In addition to its grant of a new trial due to the jury's failure to apportion *any* liability to Dr. Brara or Health Net, the trial court granted a new trial on the basis that the weight of the evidence did not support the jury's implied finding that Accountable breached the standard of care. The court's ruling set forth two bases for this determination: first, that Larue offered no expert testimony as to the standard of care of an IPA in similar circumstances; and second, that the evidence established "Accountable timely approved Plaintiff's surgery with a certificated hand surgeon at a non-contracted hospital." As we have discussed in the context of the JNOV denial, there is no obligation to offer expert testimony as to the standard of care of an IPA in these circumstances; the duty of care was well within common knowledge. More importantly, however, the trial court's

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[22] Exhibit 532 was admitted into evidence, but is not part of the record on appeal. In argument to the jury, Accountable's counsel read from the exhibit, which purportedly documents one of Larue's calls to Health Net, in which he apparently said that on Memorial Day (May 26), Dr. Weil called to say that he could not perform the surgery because Health Net would not pay Tri-City. Accountable's counsel said the document went on to report that when Larue called Health Net Consumer Care, he was told that " 'it's too high-risk cost to pay for my surgery.' " There was no objection interposed to counsel's reading of the document. At a minimum, the document supports the inference that Larue believed the denial of surgery at Tri-City was not due to Accountable's *failure to seek preauthorization* from Health Net, but rather Health Net's *denial of authorization* for it.

statement regarding timely approval of surgery at a *non-contracted* hospital does not undermine the jury's finding of liability.

Tri-City Hospital, as the testimony showed and the trial court apparently agreed, was not contracted with CommunityCare. But the documentary evidence, and the testimony of Health Net's regional network director, established that Accountable's approval of surgery at a non-contracted hospital is an empty act, unless that approval was preceded by Health Net's preapproval. As there is no evidence that Accountable obtained that preapproval, its so-called "approval" of surgery at Tri-City was ineffectual, in some sense void, and a breach of its standard of care.[23]

As neither of the reasons on which the trial court based its new trial grant with respect to Accountable's liability are supported, that portion of the new trial grant was in error.

D. *Partial New Trial is the Appropriate Remedy*

The question then arises as to the appropriate remedy on appeal when the trial court granted a full new trial on the basis that the evidence was insufficient on liability, apportionment and causation, but the new trial grant was not supported on the issue of liability.

"A reviewing court should not modify an order granting a new trial on all issues to one granting a limited new trial 'unless such an order should have been made as a matter of law.'

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[23] We reject Accountable's protective cross-appeal from the judgment, arguing insufficiency of the evidence in favor of Larue, for the same reasons.

[Citation.]" (*Schelbauer v. Butler Manufacturing Co.* (1984) 35 Cal.3d 442, 456.) We conclude this is such a case.

When the evidence of negligence is "so clear as to render it improper to submit that issue again to a court or jury," a new trial limited to issues other than liability is proper. (*Ona v. Reachi* (1951) 105 Cal.App.2d 758, 763.) Moreover, a new trial can be granted on apportionment without requiring a new trial on liability. (*O'Kelly v. Willig Freight Lines* (1977) 66 Cal.App.3d 578, 583.) This is true even though it means that, "the jury on the new trial will have to hear, and weigh, anew, all of the evidence dealing with the conduct of the parties, . . ." (*Ibid.*) The jury will, however, be instructed that it must find the defendant is at least one percent liable.

This was a lengthy hard-fought litigation, in which the jury found, on overwhelming evidence, that Accountable was liable. We see no need to require a retrial on that issue, even though a retrial on apportionment will involve much of the same evidence.

To be sure, there is some authority that "[w]here neither party requests the court below to order a limited new trial, a reviewing court is not empowered to modify an order granting a new trial on all issues to one granting a limited new trial 'unless such an order should have been made as a matter of law.' [Citation.]" (*Richard v. Scott* (1978) 79 Cal.App.3d 57, 65-66.) This rule is necessary because the power to grant a partial new trial is committed to the trial court's discretion in the first instance. (*Baxter v. Phillips* (1970) 4 Cal.App.3d 610, 617.) But here, the rule is inapplicable; the trial court believed a new trial was justified on liability, so even if it were asked, it would not have considered exercising its discretion to grant a partial new trial. It is only now, when we have determined the court's

reasons for granting a new trial on liability were inadequate, that a partial new trial is considered.

In any event, we conclude that the new trial should be partial as a matter of law. This much is clear: whether Accountable breached its duty of care toward Larue is a matter within common knowledge; every single medical professional who saw Larue believed he needed urgent hand surgery within two weeks; there is no question that Larue's CommunityCare policy provided coverage; everyone agrees the surgery should have been approved during that time; Accountable was unable to effectively approve the necessary hand surgery within the two-week window; part of this inability stemmed from Accountable's purported approval of surgery at a hospital which required preauthorization from Health Net, but that preauthorization was not obtained; part of the inability was attributable to Accountable's eleventh-hour referral to an orthopedic surgeon when a hand surgeon was requested, and the orthopedic surgeon testified he would have declined the referral if he had been asked. Under these circumstances, Accountable's liability has been established as a matter of law, and Accountable has not shown that it would be prejudiced in any way by informing the jury on retrial that it must be found liable to some degree.

3. *Partial JNOV on Civil Code Section 3428 Is Not Appropriate at This Time*

Because we affirm in part the grant of a new trial, and affirm the denial of JNOV, the matter must be remanded for a new trial. To the extent Accountable argues that we should direct a partial JNOV in its favor on Larue's cause of action under Civil Code section 3428, we conclude that the matter

should be considered in the first instance by the trial court on remand.

Civil Code section 3428, subdivision (a) provides, in pertinent part, "a health care service plan or managed care entity, as described in subdivision (f) of Section 1345 of the Health and Safety Code, shall have a duty of ordinary care to arrange for the provision of medically necessary health care service to its subscribers and enrollees, where the health care service is a benefit provided under the plan, and shall be liable for any and all harm legally caused by its failure to exercise that ordinary care when both of the following apply: [¶] (1) The failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee. [¶] (2) The subscriber or enrollee suffered substantial harm."

Accountable does not dispute that Larue presented sufficient evidence to establish the two prerequisites in subdivisions (1) and (2); it argues, however, that the statute does not apply to it, because it is not a "health care service plan or managed care entity" as defined in the statute.

As to the former, Accountable presents a straightforward argument that it is not a "health care service plan" within the meaning of Health and Safety Code section 1345, subdivision (f). That subdivision provides that "[a]ny person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees" is a health care service plan. Accountable points out that it has no members,

receives no premiums, and is not licensed by the Department of Managed Health Care (DMHC) as a health care service plan.

Accountable's argument that it is not a "managed care entity" is less obvious. It relies on a treatise's definition of "managed care organizations," as health maintenance organizations, preferred provider organizations and point of service plans, but omits that the treatise is simply referring to the *federal* meaning of the term, which is largely the equivalent of "health care service plans" in California. (Croskey et al., *supra*, ¶ 6:901, p. 6E-36.) In other words, Accountable takes the position that California's "managed care entities" are the same as federal "managed care organizations," which are themselves California "health care service plans."

Finally, Accountable relies on the uncodified portion of the statute, and its legislative history, to argue that it was meant to apply only to *health insurers*, which Accountable steadfastly argues it was not.

For his part, Larue responds that the very same treatise on which Accountable relies for its "managed care organizations" argument states that IPAs (like Accountable) *are* "health care service plans," which must either be licensed as such or legally authorized to practice medicine. (Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2017) ¶ 6:921, p. 6E-39.) Larue also argues that Accountable meets the statutory definition of a health care service plan, despite not having its own enrollees, because it provides services to enrollees of other entities.

Our review of recent developments in the regulations governing the definition of "health care service plan" and the

potential issues it raises convince us that the matter is best left for the trial court to consider in the first instance on remand.

The parties both cite to *Hambrick v. Healthcare Partners Medical Group, Inc.* (2015) 238 Cal.App.4th 124, 132. In that case, the Court of Appeal was asked to determine whether IPAs took on sufficient risk such that they should be categorized as health care service plans requiring licensure from the DMHC. The court abstained, concluding that this was "the type of regulatory determination involving complex economic policy that should be made by the DMHC in the first instance." (*Id.* at p. 149.)

The DMHC has taken to heart the *Hambrick* suggestion and has now addressed this issue. It enacted a regulation, after briefing was completed in this appeal, effective July 1, 2019. It is codified at California Code of Regulations, title 28, section 1300.49, and discusses exactly the level of risk an entity must accept to be considered a health care service plan; it also addresses the issue of whether an entity can be a health care service plan when it provides services to subscribers or enrollees of another plan without directly contracting with the enrollees. We believe discussion of whether (and when) an IPA constitutes a health care service plan appears to be a mixed question of law and fact and must take into account this new regulation. We therefore decline to address the issue further.[24]

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[24] This inquiry may also encompass factual issues insufficiently addressed in the trial court, such as the level of risk Accountable accepts with respect to other (capitated) health plans and the legal question of whether, if Accountable is a health care service plan required to be licensed by the DMHC due to its assumption of risk in its main contract with Health Net, it

DISPOSITION

The order granting a new trial is modified to grant a new trial on all issues except Accountable's liability, and as modified, is affirmed; the order denying JNOV is also affirmed. The parties are to bear their own costs on appeal.

RUBIN, P. J.

WE CONCUR:

BAKER, J.

MOOR, J.

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remains a health care service plan with respect to the non-capitated CommunityCare plan which appears in an addendum to that contract. We also note that the record does not fully document the level of risk Accountable has truly accepted with respect to CommunityCare. The agreement between Health Net and Accountable states that Health Net, not Accountable, is responsible for paying providers; but the provider agreements in evidence (Dr. Brara's and Healthpointe's) show that Accountable is responsible to pay those providers.