Filed 5/12/16 P. (CA Dept. of Managed Health Care) v. Martello CA2/1

**NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS**



IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION ONE

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| PEOPLE OF THE STATE OF CALIFORNIA, BY AND THROUGH THEIR REPRESENTATIVE, EDWARD G. HEIDIG, INTERIM DIRECTOR OF THE CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE,<br><br>Plaintiff and Respondent,<br><br>v.<br><br>JEANNETTE MARTELLO,<br><br>Defendant and Appellant. | B253947<br><br>(Los Angeles County Super. Ct. No. GC047718) |

APPEAL from a judgment of the Superior Court of Los Angeles County, David S. Milton, Judge. Affirmed.

Jeannette Martello, in pro. per., for Defendant and Appellant.

California Department of Managed Health Care, Office of Enforcement, Carol L. Ventura, Deputy Director and Chief Counsel, Drew Brereton, Assistant Chief Counsel, Kristin S. Door, Attorney III, for Plaintiff and Respondent.

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## SUMMARY

Plaintiff and Respondent the Department of Managed Health Care (hereafter DMHC) initiated a regulatory action against Defendant and Appellant Jeannette Martello, a licensed physician and board-certified plastic surgeon, (hereafter Appellant) based on Appellant's practice of "balance-billing" emergency department patients for her plastic surgery services. Appellant, in pro. per., appeals from a judgment entered against her after a bench trial, ordering Appellant to pay civil statutory penalties totaling $562,500 and enjoining her from directly billing patients treated in the emergency room for more than the co-payment, co-insurance and deductibles they are responsible for under their health plan.

We affirm.

## BACKGROUND

In July 2011, DMHC filed a civil complaint for civil penalties and injunctive relief against Appellant and her professional corporation. The complaint alleged that Appellant provided emergency care services to enrollees of health care service plans and was "balance billing"[1] enrollees in violation of Knox-Keene Health Care Service Plan Act of 1975 (Health & Saf. Code, § 1340, et. seq.)[2] and the California Supreme Court's decision in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.

The Supreme Court in *Prospect* explained the statutory scheme. "'The Knox-Keene Act is a comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care.'" (*Prospect*, *supra*, 45 Cal.4th at p. 504.)

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[1] The complaint explains "balance billing" occurs when a health plan's payment to a non-network emergency provider for the reasonable and customary value of the services rendered is less than the amount billed by the provider, and the provider attempts to collect this unpaid, outstanding balance from the enrollee.

[2] All further statutory references are to the Health and Safety Code unless otherwise noted.

Under section 1379 which was enacted in 1975, the Knox-Keene Act prohibits balance billing[3] when the health care service plan is contractually obligated to the provider to pay the bill, stating in the case of an express contract "the subscriber or enrollee shall not be liable to the provider for any sums owed under the plan" and in the case of an implied contract that "the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan." (*Prospect, supra*, 45 Cal.4th at p. 505; § 1379, subds. (a) & (b).) But under section 1317, which is not part of the Knox-Keene Act, emergency health care providers are statutorily required to provide emergency care without regard to an individual's insurance or ability to pay. (*Prospect, supra*, 45 Cal.4th at p. 504 [citing § 1317, subd. (b)].[4]) In 1994, the Legislature enacted section 1371.4, which obligates health care plans "to pay for emergency services to its subscribers." (*Prospect, supra*, 45 Cal.4th at p. 506.) Specifically, section 1371.4 provides that "[a] health care service plan . . . shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee," and further provides that "[p]ayment for emergency services and care may be denied only if the health care plan . . . reasonably determines that the emergency services were never performed . . . ." As the *Prospect* court noted, under *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, emergency service providers are permitted to sue health service plans directly over billing disputes and the Knox-Keene Act requires health service plans to provide dispute resolution mechanisms for non-contracting providers to resolve billing (§ 1367, subd. (h)(2); see § 1371.38, subd. (a)) and claims disputes and provides for penalties against health service plans if they engage in unfair payment patterns (§ 1371.37; see § 1371.39), thus protecting the interests of non-contracting

[3] The Supreme Court framed the balance billing issue as occurring "[w]hen the HMO submits a payment lower than the amount billed, can the emergency room doctors bill the *patient* for the difference between the bill submitted and the payment received– i.e., engage in the practice called 'balance billing.'" (*Prospect, supra*, 45 Cal.4th at p. 502.)

[4] As the *Prospect* court noted, federal law is similar. (42 U.S.C. § 1395dd; *Prospect, supra*, 45 Cal.4th at p. 504.)

providers in reimbursement disputes. (*Prospect, supra*, 45 Cal.4th at p. 507.) Moreover, the *Prospect* court concluded that subdivision (d) of section 1317, which requires emergency services and care to be rendered without questioning a patient's ability to pay and provides that a patient (or responsible guardian) execute an agreement or otherwise supply insurance or credit information, implicitly suggests that once patients who are members of a health service plan provide insurance information, "they have satisfied their obligation toward the doctors." (*Prospect, supra*, 45 Cal.4th at p. 506.) And section 1342, subdivision (d), expresses a legislative intent to "'[help] to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers.'" (*Prospect, supra*, 45 Cal.4th at p. 506.)

Taking all of these parts of the statutory scheme together, the Supreme Court stated the only reasonable interpretation of the scheme was that "emergency room doctors may not bill patients directly for amounts in dispute," but must resolve their differences with the health service plan and "not inject patients into the dispute." Thus, "we conclude that the doctors may not bill a patient for emergency services that the [health service plan] is obligated to pay. Balance billing is not permitted." (*Prospect, supra*, 45 Cal.4th at p. 507.)

According to the complaint in this matter, in December 2010, the DMHC served Appellant with a cease and desist order based on the Supreme Court's decision in *Prospect* and the Knox-Keene Act, but Appellant continued to collect or attempt to collect sums for emergency services from enrollees.

From June 10, 2013 to June 26, 2013, the trial court conducted an eight-day bench trial. At the conclusion of the trial, the court found that Appellant attempted to balance bill four enrollees (or their families) who went to the emergency department of a hospital for treatment of traumatic injuries.[5] In each case, the court found that Appellant rendered "emergency medical services" and the patients suffered emergency medical conditions within the meaning of Health and Safety Code section 1317.1. The court concluded that

[5] In one case, Appellant refused to bill the health plan and billed and sued the enrollee's mother.

the treatment provided by Appellant was not elective or cosmetic, but emergent and necessary to stabilize the patients' conditions. The trial court also specifically stated that it did not find Appellant's testimony to be credible and did not find her expert witnesses' to be persuasive.

The trial court enjoined Appellant from continuing to balance bill emergency department patients and imposed civil penalties of $562,500.

## DISCUSSION

On appeal, Appellant contends that the DMHC's enforcement action against her is preempted by federal law, the *Prospect* holding does not apply to her, and the trial court's decision is not supported by substantial evidence and suffers from various other defects and errors. We affirm.

### I. Presumption of Correctness

It is the appellant's burden to affirmatively demonstrate error in the challenged order, and to demonstrate the error's prejudicial impact on the appellant. On appeal, an order of the superior court is presumed to be correct. (*Denham v. Superior Court* (1970) 2 Cal.3d 557, 564.) "'All intendments and presumptions are indulged to support it on matters as to which the record is silent, and error must be affirmatively shown. This is not only a general principle of appellate practice but an ingredient of the constitutional doctrine of reversible error.'" (*Ibid.*) Accordingly, in order to prevail on appeal, the appellant must present sufficient argument and legal authority (*Niko v. Foreman* (2006) 144 Cal.App.4th 344, 368) and a sufficient record (*Oliveira v. Kiesler* (2012) 206 Cal.App.4th 1349, 1362) to demonstrate prejudicial error. Appellant meets her burden of overcoming the presumption of correctness by providing this Court with an adequate record that states what was done by the trial court and demonstrate error. (See Eisenberg et al., Cal. Practice Guide: Civil Appeals and Writs (The Rutter Group 2015) ¶ 8:19, p. 8-7.)

## II. Pro. Per. Status

A self-represented party on appeal "'is to be treated like any other party and is entitled to the same, but no greater consideration than other litigants and attorneys. [Citation.]' [Citations.] Thus, as is the case with attorneys, pro. per. litigants must follow correct rules of procedure." (*Nwosu v. Uba* (2004) 122 Cal.App.4th 1229, 1247; *Stebley v. Litton Loan Servicing, LLP* (2011) 202 Cal.App.4th 522, 524 ["Although plaintiffs appear in this court without counsel, that does not entitle them to special treatment"]; see Eisenberg et al., Cal. Practice Guide: Civil Appeals and Writs, *supra*, ¶ 9:7, p. 9-2 [citing same].)

## III. Appellant's Request for Judicial Notice and Briefing

Seven months after filing her opening brief and two months after briefing in this case was completed, Appellant filed a request for judicial notice of 67 exhibits consisting of 11 volumes and over 2,500 pages. DMHC filed an opposition, noting the late filing of the request as well as Appellant's failure to indicate whether the exhibits were noticed by the trial court or were required to be noticed under the Evidence Code.

We deny the request for judicial notice. Although there is no time-frame specified in rule 8.252 of California Rules of Court for filing a motion for judicial notice, some diligence is reasonably required and Appellant has provided no reason for the lateness of her request—made after briefing is completed and the opportunity to address the relevance of her exhibits and the arguments she believes they support in the briefing. Though "we see no objection per se to a request for judicial notice being made in a brief," "it is desirable in the interest of orderly judicial procedure that it be made well before that time." (*People v. Preslie* (1977) 70 Cal.App.3d 486, 494.) Here, in contrast, Appellant waited until after the end of briefing to make her voluminous request for judicial notice despite citing to her request throughout her opening and reply briefs. Appellant's decision not to file and serve the request for judicial notice on DMHC until after the completion of briefing rather than with her opening brief prevented an orderly opportunity for DMHC to respond to the arguments and exhibits. (See *Mangini v. R.J. Reynolds Tobacco Co.* (1994) 7 Cal.4th 1057, 1064-1065 ["Requests for judicial notice

should not be used to 'circumvent[]' appellate rules and procedures, including the normal briefing process. [Citation.] Asking that authority be judicially noticed instead of citing and discussing it in a brief gives the parties no orderly opportunity to argue the relevance of that authority or to distinguish it"].)

Moreover, "[r]eviewing courts generally do not take judicial notice of evidence not presented to the trial court. Rather, normally 'when reviewing the correctness of a trial court's judgment, an appellate court will consider only matters which were part of the record at the time the judgment was entered.'" (*Vons Companies, Inc. v. Seabest Foods, Inc.* (1996) 14 Cal.4th 434, 444, fn. 3; see *Reserve Insurance Co. v. Pisciotta* (1982) 30 Cal.3d 800, 813 ["It is an elementary rule of appellate procedure that, when reviewing the correctness of a trial court's judgment, an appellate court will consider only matters which were part of the record at the time the judgment was entered. [Citation.] This rule preserves an orderly system of appellate procedure by preventing litigants from circumventing the normal sequence of litigation"].) Here, Appellant's request for judicial notice does not indicate whether each exhibit was part of the record on appeal. To the extent that Appellant's request for judicial notice presents matters that were not presented to the trial court, Appellant has not provided an explanation as to why the matters were not presented or why we should nonetheless consider them. To the extent that some of the attached exhibits are part of the record, citation should properly have been made to the record. The record in this case consists of more than 10 volumes of reporter's transcripts, eight volumes of clerk's transcripts and five volumes of trial exhibits. We decline to undertake the laborious task of determining which of the exhibits in Appellant's voluminous request for judicial notice also appear in the record and then confirm that they are the same document.[6]

[6] To the extent the exhibits were matters presented to the trial court but erroneously omitted from the record, procedures exist to supplement or augment the record if necessary. (See Cal. Rules of Court, rule 8.155.) Indeed Appellant and DMHC filed several motions to augment the record to include missing trial court records.

Finally, we note that Appellant's citations in her briefs to the request for judicial notice refer to the exhibit number without providing any page citations. Citations to an exhibit as a whole without an exact page number are decidedly unhelpful to the court, especially when some exhibits are hundreds of pages long. Although Appellant apparently has highlighted some portions of the attached exhibits, we are still left with no reference to the pages on which these highlighted portions of text can be found. (See Cal. Rules of Court, rule 8.204, subd. (a)(1)(C) ["Support any reference to a matter in the record by a citation to the volume and page number of the record where the matter appears"]; *Myers v. Trendwest Resorts, Inc.* (2009) 178 Cal.App.4th 735, 745 ["'We are a busy court which "cannot be expected to search through the voluminous record to discover evidence on a point raised by [a party] when his brief makes no reference to the pages where the evidence on the point can be found in the record"'"]; *Nazari v Ayrapetyan* (2009) 171 Cal.App.4th 690, 694, fn. 1 ["Plaintiff's single citation to a reporter's transcript with block page references, for example, 'RT Vol. 6, 2480-2501,' frustrates this court's ability to evaluate *which facts* a party believes support his position"]; see Eisenberg et al., Cal. Practice Guide: Civil Appeals and Writs, *supra*, ¶¶ 9:36-9:37, pp. 9-12 to 9-13 [citing same].)

When an opening brief fails to make appropriate references to the record in connection with points urged on appeal, the appellate court may treat those points as waived or forfeited. (*Lonely Maiden Productions, LLC v. GoldenTree Asset Management, LP* (2011) 201 Cal.App.4th 368, 384.) DMHC argues in its brief that a number of Appellant's contentions were not raised in the trial court and Appellant's brief do not provide citations demonstrating that the matters were raised at trial. (*Dietz v. Meisenheimer & Herron* (2009) 177 Cal.App.4th 771, 779-801; see Eisenberg et al., Cal. Practice Guide: Civil Appeals and Writs, *supra*, ¶ 9:36, p. 9-12 [citing same].) Likewise, conclusory arguments without citation to recognized legal authority may be disregarded on appeal. (See *Dabney v. Dabney* (2002) 104 Cal.App.4th 379, 384; see Eisenberg et al., Cal. Practice Guide: Civil Appeals and Writs, *supra*, ¶ 9:42, p. 9-14 [citing same].)

We nonetheless specifically address several of Appellant's arguments to the extent we can distill specific contentions that are stated with relevant authority and citations.

## IV. Federal Law Issues

Appellant contends that the trial court and DMHC lacked jurisdiction, arguing that the Employee Retirement Income Security Act (ERISA), title 29 United States Code section 1001, et seq. and the Patient Protection and Affordable Care Act (PPACA), title 42 United States Code section 18001, et seq. preempt California's prohibition on balance-billing.

The ERISA and PPACA cases cited by Appellant do not support her position as none address the issue of balance billing by a provider. *Jabour v. Cigna Healthcare of California* (C.D. Cal. 2001) 162 F.Supp.2d 1119, found an enrollee's attempt to add a state law claim for breach of the implied covenant of good faith and fair dealing against the health plan was preempted because Congress intended ERISA's civil enforcement provisions to be exclusive. (*Id.* at pp. 1120, 1125.) In *Coons v. Lew* (9th Cir. 2014) 762 F.3d 891, the Ninth Circuit concluded the PPACA preempted an Arizona state law that purported to allow its citizens to forego minimum health insurance coverage and abstain from paying penalties–which was exactly what the PPACA's individual mandate required. (*Id.* at p. 901.) In *Mo. Insurance Coalition v. Huff* (E.D. Mo. 2013) 947 F.Supp.2d 1014, the district court found that the contraceptive mandate of the PPACA requiring health plans to provide contraceptive coverage without cost-sharing by enrollees preempted a state law providing that health plans could not provide contraceptive coverage to any person or entity that objected to such coverage on moral or religious grounds. (*Id.* at p. 1019.) Thus, Appellant's cited cases do not specifically address preemption in the context of balance billing or emergency services.

Finally, Appellant asserts that the PPACA specifically allows for the practice of balance billing and therefore preempts the prohibition in *Prospect* of this practice in the emergency services context. As explained in recent federal regulations: "Because the [PPACA] statute neither requires plans or issuers to cover balance billing amounts nor prohibits balance billing, even where the protections in the statute apply, patients may

still be subject to balance billing." (80 Fed. Register 72192, 72213 (Nov. 18, 2015).) The regulations, however, go on to state that the federal regulations "do no preempt existing State consumer protection laws and do not prohibit States from enacting new laws with respect to balance billing that would provide consumer protections at least as strong as the Federal statute. (80 Fed. Register 72192, 72213 (Nov. 18, 2015).) In short, we find no support for Appellant's claim that California's prohibition against balance billing in the emergency services context is preempted by federal law.

## V. Knox-Keene Act

Having concluded that Appellant has failed to show that California's statutory scheme is preempted by federal law, we turn to the application of the Knox-Keene Act to Appellant. Appellant contends that she is an on-call specialist, not an "emergency room doctor" or "emergency room physician," citing the definition of "emergency physician" in section 127450, subdivision (c)[7] and various cases, and argues therefore *Prospect* does not apply to her.

In *Prospect*, the Supreme Court explained that, for ease of discussion, it was referring "rather loosely to those required to provide emergency services without regard to the patient's ability to pay as emergency room doctors, while recognizing that the category is broader than just doctors." (*Prospect*, *supra*, 45 Cal.4th at p. 501, fn. 1.) *Prospect* did not specifically address on-call specialists such as Appellant but clearly acknowledged that the category of providers it was discussing was broader than just "emergency doctors" and included all those required to provide emergency services without regard to the patient's ability to pay. Likewise, section 1371.4, subdivision (b) provides that a health care service plan "shall reimburse providers for emergency services and care provided to its enrollees" and is not limited to emergency physicians or emergency doctors. Rather the reasoning in *Prospect* makes clear that if a provider—

[7] Section 127450 addresses emergency physician fair pricing policies and is not part of the Knox-Keene Act. Subdivision (c) defines emergency physician to exclude a "physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside the emergency department."

irrespective of whether the provider is an "emergency doctor"—has recourse against the patient's health plan, the provider must pursue its claims against the health plan if the provider is dissatisfied with the amounts paid by the plan and cannot "inject" the patient into a dispute.[8] Thus, the issue is not whether Appellant was an "emergency doctor" but whether she provided emergency services and therefore could seek payment from the plan for her services.

The *Prospect* court noted that while the case was pending, the DMHC adopted a regulation defining balance billing as an unfair billing pattern. (*Prospect, supra*, 45 Cal.4th at p. 510.) Although the court did not rely on the regulation—or its previous absence—in reaching its conclusions in *Prospect* (*id.* at p. 510), the regulation makes clear that on-call specialist are included in the prohibition against balance billing for emergency services, stating that unfair billing pattern includes "the practice by a provider of emergency services, including but not limited to hospitals and hospital-based physicians such as . . . on-call specialists, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan . . . for the provision of emergency services." (Cal. Code Regs., tit. 28, § 1300.71.39.)

## VI. Substantial Evidence Claims

The trial court concluded that Appellant did provide emergency services to the four patients that were part of the trial and did receive some payment from the health care plans. Appellant's brief does not contain a statement of facts and her argument section does not provide a fair summary of all the material evidence. Thus, to the extent Appellant asserts that the trial court's various factual findings—including that Appellant provided the enrollee's emergency medical services and received or could have sought payment from the plans for those services, that patients' condition and circumstances at the time Appellant's treatment required emergency services, and that Appellant was

[8] "Our holding is limited to the precise situation before us–billing the patient for emergency services when the doctors have recourse against the patient's [health service plan]. We express no opinion regarding the situation when no such recourse is available; for example, if the [health service plan] is unable to pay or disputes coverage." (*Prospect, supra*, 45 Cal.4th at p. 507, fn. 5.)

aware of the decision in *Prospect* as well as a cease and desist order from DMHC against her—were not supported by substantial evidence, these arguments are arguably waived or forfeited. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 881; *Arechiga v. Dolores Press, Inc.* (2011) 192 Cal.App.4th 567, 571-572; see Eisenberg et al., Cal. Practice Guide: Civil Appeals and Writs, *supra*, ¶¶ 8:70-8:71, pp. 8-37 to 8-38 [citing same].)

In any event, even if we were to consider Appellant's substantial evidence arguments, Appellant had a very difficult burden to show error. In reviewing the sufficiency of the evidence, we consider the evidence in the light most favorable to the respondent and accept as true all the evidence and reasonable inferences that support the trial court's decision, and resolve every conflict in favor of the judgment. (*Garlock Sealing Techs., LLC v. NAK Sealing Techs. Corp.* (2007) 148 Cal.App.4th 937, 951.) """It is not our task to weigh conflicts and disputes in the evidence; that is the province of the trier of fact. Our authority begins and ends with a determination as to whether, on the entire record, there is any substantial evidence, contradicted or uncontradicted, in support of the judgment."""" (*Ibid.*) Here, the trial court determined in each of the cases at issue that Appellant rendered "emergency medical services," the patients suffered emergency medical conditions within the meaning of Health and Safety Code section 1317.1, and that the treatment provided by Appellant was not elective or cosmetic, but emergent and necessary to stabilize the patients' conditions. Substantial evidence supported these determinations and while Appellant's testimony and other evidence may have been to the contrary, we do not reweigh the evidence or reassess credibility on appeal. To the extent Appellant challenges the trial court's credibility determinations or the weight of the evidence as, for example, when there was conflicting testimony, we neither reweigh the evidence nor reassess credibility determinations, as the "Court of Appeal is not a second

trier of fact." (*In re Marriage of Balcof* (2006) 141 Cal.App.4th 1509, 1531; *Estate of Young* (2008) 160 Cal.App.4th 62, 76.)[9]

We find no merit to Appellant's remaining arguments and, as discussed previously, we decline to address Appellant's arguments that are unsupported by citation to the record and relevant legal authority or were not raised below.

**DISPOSITION**

We affirm. Respondent shall recover its costs on appeal.

NOT TO BE PUBLISHED.

CHANEY, J.

We concur:

ROTHSCHILD, P. J.

JOHNSON, J.

[9] Similarly, to the extent Appellant contends that she was not served with a copy of the DMHC's December 30, 2010, cease and desist order, the trial court found her testimony on this issue to be "evasive and not credible" and substantial evidence supported the trial court's conclusion that Appellant had received notice of the order.