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Wickline v. State: The Emerging Liability of Third Party Health Care Payors

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Modern medicine is experiencing a tension that revolves around the need for quality medical care and the concurrent problem of the rising cost of medical services. Third party payors are being pressured by California courts to provide carefully designed benefit programs that allow physicians to make quality health care decisions without having to worry about the payment source of additional costs. This Comment assesses the effect of third party payor liability for poor health care — does its cost outweigh its benefit?

INTRODUCTION

Nearly half of all physicians feel pressured to release Medicare patients early. This pressure results from a tension in medicine today, the stress between the quality of medical care and medical economics. Americans believe that the ability to pay should never create a barrier to essential medical care, yet skyrocketing medical costs make financial considerations an integral part of medical treatment decisions.

On opposing sides of this conflict are the patient and the third party health care payor. The patient expects to receive the best medical care available, while the third party payor wishes to limit coverage to essential medical services. Until now, physicians have been caught in the middle. Exceeding the scope of the third party payor's treatment authorization may result in nonpayment. Failure to meet or exceed the standard of care may result in a malpractice suit. Physicians consequently may be forced to provide treatment without

2. 29 Am. Med. News 17 (1986). Out of 1000 physicians randomly surveyed by the American Medical Association, 48% felt "unduly pressured" to release Medicare patients prematurely because of reimbursement concerns. Twenty-eight percent felt no pressure, and the remaining 25% either were unsure or did not respond to the survey. See also San Diego Union, Dec. 5, 1986, at A-13, col. 1.
4. See infra note 22.
This tension recently reached a peak in a California case, *Wickline v. State*. The court, considering the position of the physician caught between patient and third party payor, addressed for the first time potential third party payor liability for negligent treatment authorization decisions.

To appreciate the implications of *Wickline*, a general understanding of medical cost containment strategies is essential. This Comment will review methods of medical cost control employed by third party payors, present the factual background and holding of *Wickline*, address the issue of governmental tort immunity as applied to public health care payors, and discuss the impact of *Wickline* on third party payors and health care providers respectively. The conclusion suggests that the ultimate costs of third party payor liability may outweigh the benefits.

**BACKGROUND**

In 1965, Congress created Medicare to provide mainstream medical care to the elderly on a national level. In the same year, Congress made federal assistance available under Medicaid to states establishing medical care programs for low-income individuals. California’s program under Medicaid is called Medi-Cal.

Initially, both Medicare and Medi-Cal relied on retrospective utilization review for payment of claims and cost containment. Under a retrospective system, the third party payor reimburses the health care provider’s reasonable cost of treatment after the treatment is rendered. Regardless of whether the third party payor ultimately approves or denies the claim for treatment, the patient is assured access to necessary health care.

Unfortunately, retrospective utilization review proved economically disastrous. Because claims rarely were denied, an incentive existed for health care providers to overtreat in order to maximize profits. The problem was compounded further by the combined effects of soaring medical costs and increased demand for health care

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5. See infra note 23.
7. Id. at 1190, 228 Cal. Rptr. at 671.
9. Id.
12. Id.
14. Id. at 9. See Peer Grouping Hospitals, supra note 11, at 12.
services.\(^\text{15}\) By the early 1970s, cost projections under the existing retrospective review system threatened enormous budget overruns and the ultimate demise of government-funded health care programs.\(^\text{16}\) In response to this crisis, legislatures abandoned retrospective utilization review in favor of prospective utilization review.\(^\text{17}\) Unlike retrospective review, where a claim for treatment is reviewed after the fact, prospective review requires that a health care provider obtain authorization from the third party payor before initiating treatment.\(^\text{18}\)

Prospective utilization review is an effective cost containment mechanism. Because only pre-authorized treatment is paid for, health care providers have no incentive to overtreat in hopes of increased compensation. Rather, they constantly are reminded that when they exceed the pre-authorized scope of treatment, they very likely are working for free.\(^\text{19}\)

Prospective review has restructured medical decisionmaking. Traditionally, medical treatment decisions involved only two parties, the physician and the patient.\(^\text{20}\) Under prospective review, the third party payor now plays an active role in determining both the course and scope of treatment.\(^\text{21}\) For the first time, the "final say" in the medical decisionmaking process is placed beyond the control of both the physician and the patient.

The goals of the patient and the third party payor are opposite. The patient is concerned with receiving the highest quality health care available, and the third party payor primarily is concerned with the efficient administration of limited funds. Both public and private third party payors must ensure that health care dollars provide essential treatment for many, rather than excessive treatment for few. Third party payors seek to limit individual treatment to the essential minimum.\(^\text{22}\) By fostering these opposing goals, cost containment pro-


\(^\text{16}\) Id. See also Note, \textit{Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting}, \textit{98 HARV. L. REV.} 1004, 1005 (1985).


\(^\text{18}\) See Amicus Curiae Brief, Respondent, \textit{supra} note 13, at 4.

\(^\text{19}\) Id. at 9.

\(^\text{20}\) Id. at 11.

\(^\text{21}\) Id.

\(^\text{22}\) See generally Amicus Curiae Brief on Behalf of Cost Care, Inc. in Support of Appellant, Wickline v. State 183 Cal App. 3d 1175, 228 Cal. Rptr. 661 (1986) [hereinafter Amicus Curiae Brief, Appellant].
grams such as prospective utilization review have created a tension in medicine, with the physician caught in the middle. If the physician withholds essential treatment because the third party payor refuses authorization, he may be sued by the patient for failure to conform to the standard of care. If the physician provides the unauthorized treatment, he runs the risk of nonpayment. No longer given the final authoritative say in treatment decisions, the physician must balance the competing interests of the patient and the third party payor, and try to avoid both the courtroom and the poorhouse in the process.\(^\text{23}\) This tension is the focus of *Wickline v. State*.\(^\text{24}\)

**WICKLINE v. STATE**

In 1976, Lois Wickline, a Medi-Cal recipient, underwent surgery for a condition known as Leriche's Syndrome.\(^\text{25}\) Wickline's recovery was "stormy," and post-surgical complications necessitated several subsequent operations. Because Wickline was a Medi-Cal recipient, her physicians obtained pre-authorization for surgery and ten days of post-surgical hospitalization. On the ninth day of hospitalization, Wickline's surgeon concluded that, due to the post-surgical complications, an eight day extension of hospitalization was necessary.\(^\text{26}\)

A request for eight additional days of hospitalization was submitted to Medi-Cal through proper channels and ultimately was considered by a Medi-Cal consultant.\(^\text{27}\) In an arguably negligent decision, rendered without consulting a specialist, the Medi-Cal consultant approved only a four day extension of hospitalization for Wickline, rather than the eight days requested.\(^\text{28}\) Accordingly, Wickline's phy-


\(^{24}\) 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986).

\(^{25}\) *Id.* at 1179, 228 Cal. Rptr. at 663-64. *See also* DORLAND'S ILLUSTRATIVE MEDICAL DICTIONARY 1293 (26th ed. 1985). Leriche's Syndrome is an arteriosclerotic obstruction of the abdominal aorta, a portion of the main artery of the body that supplies blood to the lower extremities. In Ms. Wickline's case, it was necessary to remove the blocked portion of the aorta and replace it with a synthetic graft.

\(^{26}\) *Wickline*, 183 Cal. App. 3d at 1181, 228 Cal. Rptr. at 665. Repeated post-surgical clotting of the synthetic graft threatened the circulation in Ms. Wickline's right leg, and necessitated further surgery and hospital monitoring.

\(^{27}\) *Id.*. The request for additional hospitalization initially was considered by a Medi-Cal "on-site" nurse, who reviewed the request form at Ms. Wickline's hospital. The authority of Medi-Cal on-site nurses is limited to approval of requests. If the nurse is unable to approve additional hospital time, he or she must contact a Medi-Cal consultant, a licensed physician employed by Medi-Cal, to make the final decision on the request. In the instant case, the Medi-Cal on-site nurse was unable to approve the request and telephoned a Medi-Cal consultant for the final decision. *See* Amicus Curiae Brief, Respondent, *supra* note 13, at 26.

\(^{28}\) *Wickline*, 183 Cal. App. 3d at 1183, 228 Cal. Rptr. at 666. The Medi-Cal consultant based his decision upon the lack of information regarding Ms. Wickline's temperature, diet, and bowel sounds, which he assumed were all normal. Respondent argued that these parameters were of only tangential significance to the central problem of the
sicians released her from the hospital at the end of four days. Her complications persisted at home, and delay in diagnosis and treatment ultimately required the amputation of her right leg.29

Wickline brought suit against the state for negligent discontinuance of her Medi-Cal eligibility. At trial, Wickline’s treating physicians testified that the decision to release her at the end of four days complied with the standard of care. They also stated, however, that had she remained in the hospital for the requested eight days, her leg probably could have been saved.30

A physician consultant for Medi-Cal testified on behalf of the state. The consultant stated that if Wickline’s physicians had determined that her release after four days was unwise, they could have procured an authorized extension of hospitalization by a simple phone call and explanation to the Medi-Cal consultant. Wickline’s treating physicians concurred with this view, and admitted they would have called Medi-Cal and obtained an extension had they felt any danger existed in discharging Wickline after four days.31

The jury found the state liable for Wickline’s injury, and the state appealed. The appellate court reversed the judgment, and absolved the state from liability as a matter of law, holding that a physician bears the ultimate responsibility for treatment decisions. The court reasoned that because the treating physician is in the best position to determine the medical needs of the patient, the third party payor relies upon the physician’s input in making pre-authorization decisions. The court found that the decision to discharge Wickline was arrived at independently by her treating physicians, who were aware that a phone call to Medi-Cal would have procured additional hospitalization.32

reocclusion of Ms. Wickline’s graft. The evidence also suggests that the consultant could have taken several steps to more fully apprise himself of Ms. Wickline’s condition. Specialists in peripheral vascular surgery, similar to Ms. Wickline’s surgeon, were employed by Medi-Cal and made available to consultants for consultation in areas beyond their immediate expertise. The consultant in the instant case, although not a peripheral vascular specialist, did not obtain such consultation prior to acting. The consultant also had access to documentation of Ms. Wickline’s initial hospitalization and surgery, but failed to review it prior to reducing the requested number of hospital days.

29. Id. at 1186, 228 Cal. Rptr. at 668. Ms. Wickline’s graft reoccluded at home, and, by the time she was rehospitalized, infection at the wound site made it medically unsafe to relieve the obstruction by surgery.

30. Id. at 1178, 1187, 228 Cal. Rptr. at 663-64, 669.

31. Id. at 1190, 228 Cal. Rptr. at 671. Appellant’s Opening Brief at 29, Wickline v. State, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986) [hereinafter Appellant’s Brief].

32. Wickline, 183 Cal. App. 3d at 1177, 1189, 228 Cal. Rptr. at 663, 673.
Although holding the physicians ultimately liable for Wickline's injuries, the court also discussed the larger issue of third party payor liability. The court suggested that, had Wickline's physicians asked for an extension on the last day, and had Medi-Cal unreasonably refused, liability for Wickline's injuries would have shifted to the state. The court acknowledged the potential liability of third party payors, stating:

Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.

**GOVERNMENTAL IMMUNITY**

**Discretionary v. Ministerial Acts**

Although the issue of governmental tort immunity was raised by the parties in Wickline, in the court's opinion it receives only brief consideration. Recognition of potential third party payor liability implies that institutions such as Medi-Cal would not be protected by government immunity. Nevertheless, a brief discussion of government tort immunity serves to illustrate the function of the Medi-Cal consultant and the potential immunity of government third party payors.

The pivotal issue in governmental tort immunity involves characterization of the contested act as either "ministerial" or "discretionary." Government Code section 820.2 makes public employees immune from the consequences of discretionary decisions. Government Code section 815.2(b) extends such immunity to the public entity employing the employee.

The current test for characterizing acts as ministerial or discretionary under Government Code section 820.2 was established in the seminal case of *Johnson v. State*. Before *Johnson*, courts employed

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33. *Id.* at 1190, 228 Cal. Rptr. at 671.
34. *Id.*
37. **Cal. Gov't Code** § 820.2 (West 1980) provides: Except as otherwise provided by statute, a public employee is not liable for an injury resulting from his act or omission where the act or omission was the result of the exercise of the discretion vested in him, whether or not such discretion was abused.
38. **Cal. Gov't Code** § 815.2(b) (West 1980) provides in pertinent part: "[A] public entity is not liable for an injury resulting from an act or omission of an employee of the public entity where the employee is immune from liability."
a mechanical, semantic approach in defining "discretionary" acts.\footnote{40} The court in \textit{Johnson} rejected this mechanical approach,\footnote{41} favoring instead a functional approach that focused on the underlying policy reasons for granting immunity.\footnote{42}

The \textit{Johnson} court held that the only valid purpose for granting discretionary immunity was protection of the "separation of powers" doctrine, and emphasized that courts must be sensitive to judicial interference in policy decisions made by coordinate branches of government.\footnote{43} The court suggested that the discretionary/ministerial dichotomy should be characterized as the difference between the "planning" and "operational" levels of decisionmaking. Immunized discretionary actions were identified as quasi-legislative policy making decisions involving a deliberate balancing of risks and advantages.\footnote{44}

In \textit{Johnson}, a parole agent placed a juvenile parolee in a foster

\begin{thebibliography}{99}
\bibitem{40} A. Van Alstyne, \textit{California Government Tort Liability Practice}, \S 2.55, at 115 (2d ed. 1986). Prior to \textit{Johnson}, courts struggled with a semantic definition of discretionary, finding that nearly every act could be described as discretionary in some regard: "[I]t would be difficult to conceive of any official act, no matter how directly ministerial, that did not admit of some discretion in the manner of its performance, even if it only involved the driving of a nail." Ham v. County of Los Angeles, 46 Cal. App. 148, 162, 189 P. 462, 468 (1920).
\bibitem{41} \textit{Johnson}, 69 Cal. 2d at 787, 447 P.2d at 356, 73 Cal. Rptr. at 244.
\bibitem{42} \textit{Id.} at 788, 447 P.2d at 357, 73 Cal. Rptr. at 245.
\bibitem{43} \textit{Id.} at 793, 447 P.2d at 360, 73 Cal. Rptr. at 248. The court stated: Courts and commentators therefore have centered their attention on an assurance of judicial abstention in areas in which the responsibility for \textit{basic policy decisions} has been committed to coordinate branches of government. Any wider judicial review, we believe, would place the court in the unseemly position of determining the propriety of decisions expressly entrusted to a coordinate branch of government. Moreover, the potentiality of such review might even in the first instance affect the coordinate body's decision-making process.
\bibitem{44} \textit{Id.} at 794, 447 P.2d at 360-61, 73 Cal. Rptr. at 248-49. The court stated: Our proposed distinction, sometimes described as that between the "planning" and "operational" levels of decision-making, however, offers some basic guideposts, although it certainly presents no panacea. Admittedly, our interpretation will necessitate delicate decisions; the very process of ascertaining whether an official determination rises to the level of insulation from judicial review requires sensitivity to the considerations that enter into it and an appreciation of the limitations on the court's ability to reexamine it. Despite these potential drawbacks, however, our approach possesses the dispositive virtue of concentrating on the reasons for granting immunity to the governmental entity. It requires us to find and isolate those areas of quasi-legislative policy-making which are sufficiently sensitive to justify a blanket rule that courts will not entertain a tort action alleging that careless conduct contributed to the governmental decision.
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home. Although he knew of the youth's violent tendencies, the parole agent failed to warn the foster parents of any danger. When the youth subsequently attacked and seriously injured the foster mother, she sued the state for the parole agent's negligent failure to warn.46

Applying the above analysis, the court distinguished two types of acts. First, the court found that the initial decision to parole the youth required the careful balancing of potential risks and benefits. The court concluded that because parole decisions require the resolution of policy considerations, these decisions qualify as discretionary acts and are immune from judicial scrutiny.46 Second, the court characterized the parole agent's decision not to warn the foster parents as a nonimmunized ministerial act because it merely involved the implementation of the overlying policy decision to parole.47

Characterizing the Medi-Cal Consultant's Decision as Discretionary

Several arguments support characterization of the Medi-Cal consultant's decision in Wickline as discretionary, and therefore immune from liability. First, where a statutory scheme confers broad discretionary powers upon a public employee, the employee is immune under Government Code section 820.2.48

The basis for this argument lies in the statutory description of the Medi-Cal consultant's duties. Welfare and Institutions Code section 14132 (b)49 provides that in-patient hospital services shall be subject to utilization controls. Welfare and Institutions Code section 14133(a)50 defines utilization controls as prior authorization of medical services rendered by a Health Department consultant based upon a determination of medical necessity.

Welfare and Institutions Code section 14103.651 authorizes Medi-Cal "on-site" nurses to approve, but not deny, requests for medical services under the supervision of Medi-Cal consultants. Section 50009 of Title 22 of the California Administrative Code52 defines the term "Medi-Cal consultant," and sections 51159(a)53 and 51003(a)54 provide that the Medi-Cal consultant shall not only make the initial pre-authorization decision, but also review the decision at

45. Id. at 784-85, 447 P.2d at 354, 73 Cal. Rptr. at 242.
46. Id. at 795, 447 P.2d at 361, 73 Cal. Rptr. at 249.
47. Id. at 795-96, 447 P.2d at 362, 73 Cal. Rptr. at 250.
48. CAL. GOV'T CODE § 820.2. See Appellant's Brief, supra note 31, at 52.
49. CAL. WELF. & INST. CODE § 14132(b) (West Supp. 1987).
51. CAL. WELF. & INST. CODE § 14103.6 (West Supp. 1987).
52. CAL. ADMIN. CODE tit. 22, § 50009 (West 1986).
53. CAL. ADMIN. CODE tit. 22, § 51159(a).
54. CAL. ADMIN. CODE tit. 22, § 51003(a).
the first level of appeal. Section 51327(a)(3) provides that requests for nonemergency hospitalization, such as occurred in Wickline, require prior authorization by a Medi-Cal consultant.

Under this statutory scheme, the pre-authorization decision of a Medi-Cal consultant could be characterized as discretionary by definition. In determining the "medical necessity" of requested treatment, the consultant not only balances the potential risks and benefits in light of his or her independent medical judgment, but also weighs considerations of the fair and efficient allocation of limited funds for the public welfare. Characterization of the consultant's decision as discretionary is strengthened by comparison to decisions of the "on-site" nurse. Although allowed to approve treatment requests based on medical evaluation, the nurse is prohibited from denying such requests, and must defer to higher authority. The nurse's function could be characterized as ministerial because the exercise of judgment is strictly circumscribed and subject to external review. The limited scope of choice suggests the "operational" level of decisionmaking, where the nurse is limited to a one-way application of a pertinent rule.

The Medi-Cal consultant, by contrast, enjoys full power to authorize or refuse treatment requests, and is responsible for the first level of appellate review of his or her own decisions. The consultant's initial decision incorporates the first level of appellate review, with the attendant consideration of conflicting policies. This decisional process could be construed as rising to the "planning" level of government action and accordingly immunized from judicial review.

A second argument for immunizing the decisions of Medi-Cal consultants is avoidance of frustration of legislative purpose. Imposition of tort liability could result in Medi-Cal consultants becoming preoccupied with liability avoidance rather than efficient administration. This would contravene Medi-Cal's fundamental purpose of allocating limited public funds in the fairest way possible.

55. CAL. ADMIN. CODE tit. 22, § 51327(a)(3).
56. Appellant's Brief, supra note 31, at 58.
57. See supra notes 27 and 52 and accompanying text.
58. See supra note 54 and accompanying text.
60. CAL. WELF. & INST. CODE § 14000 (West Supp. 1987). But see Johnson, 69 Cal. 2d at 790, 447 P.2d at 358, 73 Cal. Rptr. at 246, where the court, in rejecting this argument, held: "The danger that public employees will be insufficiently zealous in their official duties does not serve as a basis for immunity in California." (emphasis in original). The court reasoned that government employees were adequately indemnified against personal liability by the state, and awareness of potential liability promoted the
A third argument construes Government Code section 818.4 as bestowing discretionary immunity on Medi-Cal consultants. The consultant’s decision could be characterized as an “approval” or “authorization” within the meaning of the statute. In *Morris v. County of Marin*, the court defined ministerial acts as those which create a mandatory duty under Government Code section 815.6.

In *Morris*, the county was charged with a duty to ensure that applicants for building permits had obtained worker’s compensation insurance. The county’s failure to fulfill this statutory duty was held to be a ministerial act, because obtaining proof of insurance was a mandatory requirement rather than a discretionary decision.

The treatment authorization decisions of Medi-Cal consultants, by contrast, involve no such mandatory duty. The decisions of the Medi-Cal “on-site” nurse, limited to either approval or deferral, seem more mandatory than those of the consultant, who is given unlimited authority with respect to decisionmaking. Thus, the treatment authorization decisions of Medi-Cal consultants arguably could qualify as discretionary acts under Government Code section 818.4.

**Characterizing the Medi-Cal Consultant’s Decision as Ministerial**

Equally persuasive arguments support the characterization of Medi-Cal consultants’ decisions as purely ministerial. First, in negligence cases, liability is the rule and immunity the exception. When governmental immunity is raised as a defense, a presumption in favor of the injured plaintiff usually arises.

Second, Government Code section 855.6 imposes liability in cases of medical examination or diagnosis for treatment purposes. The Medi-Cal consultant exercises independent medical judgment in reviewing treatment requests. These decisions therefore could be construed as medical examinations or diagnoses relative to treatment exercise of care in the performance of official duties.

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61. CAL. GOV'T CODE § 818.4 (West 1980 & Supp. 1987) provides as follows:
A public entity is not liable for an injury caused by the issuance, denial, suspension or revocation of, or by failure or refusal to issue, deny, suspend or revoke, any permit, license, certificate, approval, order, or similar authorization where the public entity or an employee of the public entity is authorized by enactment to determine whether or not such authorization should be issued, denied, suspended or revoked.


64. *Id.* at 910, 559 P.2d at 612, 136 Cal. Rptr. at 257. *See infra* notes 82-84 and accompanying text.


66. *See supra* notes 27 and 54 and accompanying text.


of individual patients. If the consultant's decisions fall within section 855.6, tort immunity under Government Code sections 820.2 and 818.4 could be eliminated under the statutory construction canon favoring specific statutory language over general.

Third, the case of Bohrer v. County of San Diego withholds discretionary immunity in the medical setting. In Bohrer, the alleged negligent prescription of medication by a county physician resulted in a mental patient's death. The court held that the physician's medical decision did not rise to the policymaking level, and thus did not justify the imposition of discretionary immunity under Government Code section 820.2. If treatment authorization decisions of Medi-Cal consultants are products of independent medical judgment, such decisions may be denied discretionary immunity under both section 855.6 and Bohrer.

A challenge to discretionary immunity under the statutory definition of the Medi-Cal consultant's role is a fourth approach. Adoption of the prospective utilization review process by the Department of Health Services could be characterized as a discretionary policy decision, requiring protection from judicial scrutiny. Application of the prospective review process in individual cases by the Medi-Cal consultant, however, could be construed as a purely ministerial act. The consultant does not "make policy" by deciding which method of utilization review to adopt, but merely applies the existing scheme at the "operational" level.

The consultant's role in the patient's course of treatment is relatively passive and could be considered a fifth basis for denial of discretionary immunity. The treating physician actively exercises his medical judgment in selecting and requesting a specific course of treatment for an individual patient. By contrast, the Medi-Cal consultant passively reviews the treating physician's request for completeness and considers whether the request contains sufficient detail to justify authorization. The consultant's decision entails no balancing of conflicting policy considerations nor the exercise of independent medical judgment.

A sixth argument would challenge discretionary immunity for a Medi-Cal consultant under Government Code section 818.4, which

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70. 104 Cal. App. 3d 155, 163 Cal. Rptr. 419 (1980).
71. Id. at 162, 163 Cal. Rptr. at 423.
73. Id.
74. Respondent's Brief, supra note 35, at 43, 44.
applies to government entities involved in licensing activities. Because section 818.4 could be interpreted to apply exclusively to licensing-type activities, it would not apply to prospective utilization review in the medical setting.

Seventh, a mandatory duty could be imposed on the state under *Morris*. In *Morris*, the court construed Government Code section 815.6 to deny discretionary immunity where the state fails to fulfill a mandatory duty imposed by statute. The court held that discretionary immunity was not available as a defense for the county's failure to obtain proof of worker's compensation insurance as required by Labor Code section 3800.

When read together, Welfare and Institutions Code sections 14000 and 14133 impose a mandatory duty on Medi-Cal to establish prospective review programs to ensure that Medi-Cal beneficiaries receive adequate care. In *Wickline*, the fact that Ms. Wickline did not receive adequate care under the prospective review system raises an inference of noncompliance by Medi-Cal with this statutory duty. Under Government Code section 815.6 as construed in *Morris*, Medi-Cal would be denied discretionary immunity from the consequences of the consultant's decision.

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76. Respondent's Brief, supra note 35, at 49. Authorization of medical treatment does not fit within the meaning of "licensing activities" considered by cases construing section 818.4, most of which involve issuance of licenses or permits. See A. V. ALSTYNE, supra note 40, at 149.

77. 18 Cal. 3d 901, 559 P.2d 606, 136 Cal. Rptr. 251 (1977).

78. CAL. GOV'T CODE § 815.6 (West 1980 & Supp. 1987) provides as follows:

Where a public entity is under a mandatory duty imposed by an enactment that is designed to protect against the risk of a particular kind of injury, the public entity is liable for an injury of that kind proximately caused by its failure to discharge the duty unless the public entity establishes that it exercised reasonable diligence to discharge the duty.


80. Id. at 910-11, 559 P.2d at 612, 136 Cal. Rptr. at 257. See CAL. LAB. CODE § 3800 (West 1971).

81. CAL. WELF. & INST. CODE § 14000 (West Supp. 1987) provides in pertinent part that Medi-Cal recipients should be able "whenever possible and feasible . . . to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability."

82. CAL. WELF. & INST. CODE § 14133 (West 1980 & Supp. 1987) provides in pertinent part:

Utilization controls that may be applied to the services set forth in Section 14132 which are subject to utilization control shall be limited to:

(a) Prior authorization, which is approval by a department consultant, of a specified service in advance of the rendering of that service based upon a determination of medical necessity.

83. CAL. WELF. & INST. CODE § 14133.1 (West Supp. 1987) provides in pertinent part: "[E]ach utilization control shall be reasonably related to the purpose for which it is imposed."

84. Amicus Curiae Brief, Respondent, supra note 13, at 26.
The foregoing arguments highlight the complexity and importance of the issues involved in determining the existence of discretionary immunity. On balance, the Medi-Cal consultants' treatment authorization decisions do not appear realistically to be the product of a quasi-legislative balancing of conflicting policy considerations. The consultants' decisional process seems closer to the "operational" than the "planning" level, and appears simply to involve the application of the approved method of utilization review.

The Effect of Liability on Third Party Payors

Protection Under MICRA

If third party payors are exposed to medical liability, they should be treated no differently from other health care defendants. Apparently, however, the statutory protection currently afforded medical malpractice defendants may be unavailable to third party payors. In 1975 the California legislature enacted the Medical Injury Compensation Reform Act (MICRA) in response to a perceived medical malpractice crisis. The purpose of MICRA is to ensure the continued availability of medical liability insurance through reduction of malpractice awards and attorney's fees.

MICRA creates four exceptions to traditional tort recovery principles in medical malpractice actions. First, California Civil Code section 3333.1 abrogates the collateral source rule and allows introduction of any collateral benefits paid to plaintiffs. Second, California Civil Code section 3333.2 placed a $250,000 limit on recovery of noneconomic damages in a single action. Third, California Civil Procedure Code section 677.7 creates an exception to the rule requiring...
ing lump sum payments of judgment awards.\textsuperscript{91} Fourth, California Business and Professions Code section 6146 places a sliding scale restriction on the recovery of contingent fees by plaintiffs' attorneys.\textsuperscript{92}

The provisions of MICRA apply only to actions for injury or damage against "health care providers." The common definition of "health care provider" used throughout MICRA refers to appropriately licensed individuals or health care facilities.\textsuperscript{93} Third party payors of health care services are not mentioned. Third party payors do not logically qualify as "health care providers." Third party payors do not "provide" health care; they pay for it. A treatment authorization decision of a third party payor, although capable of influencing the scope of treatment, does not logically constitute "provision" of treatment under any interpretation.

Third party payors probably were excluded from protection under MICRA because the drafters did not envision third party payor liability. In the absence of specific legislative action to the contrary, third party payors must bear the inequity of sharing liability while denied the statutory protection afforded other medical malpractice defendants.

\textit{Other Statutory Inconsistencies}

MICRA is not the only legislation under which "health care providers" receive special treatment. California Code of Civil Procedure sections 340.5\textsuperscript{94} and 364\textsuperscript{95} govern the statute of limitations and commencement of actions requirements pertaining to health care providers respectively. Section 340.5 provides for an extended statute of limitations in medical malpractice cases beyond the one year statute for conventional torts.\textsuperscript{96} Section 364 requires a medical malpractice

\textsuperscript{91} CAL. CIV. PROC. CODE § 667.7 (West 1980).
\textsuperscript{92} CAL. BUS. & PROF. CODE § 6146 (West Supp. 1987).
\textsuperscript{93} Each section of MICRA incorporates the following definition of "health care provider":

"Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to division 2 (commencing with section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

CAL. CIV. CODE §§ 3333.1(c)(1), 3333.2(c)(1) (West Supp. 1987); CAL. CIV. PROC. CODE § 667.7(e)(3) (West 1980); CAL. BUS. & PROF. CODE § 6146(c)(2) (West Supp. 1987).

\textsuperscript{94} CAL. CIV. PROC. CODE § 340.5 (West 1982).
\textsuperscript{95} CAL. CIV. PROC. CODE § 364 (West 1982).
\textsuperscript{96} CAL. CIV. PROC. CODE § 340.5. The purpose behind section 340.5 is to allow plaintiffs time to discover injuries that may not become apparent until years after the
plaintiff to give a health care provider ninety days advance notice of intention to commence action.\textsuperscript{97} Each section incorporates the definition of "health care provider" used in MICRA.\textsuperscript{98}

Under the foregoing analysis, these statutes equally are inapplicable to third party payors because they fall outside the definition of "health care provider." Third party payors benefit by avoiding section 340.5 because they fall under Code of Civil Procedure section 340,\textsuperscript{99} which favors defendants by providing a shorter statute of limitations for tort actions. Third party payors, however, lose the advantage of the ninety day advance notice of intention to commence action required under section 364.

In either case, the disparate application of these statutes will complicate the trial of multiple defendant medical malpractice actions in which a third party payor is named. Although plaintiffs' attorneys will be encouraged to name third party payors not protected by MICRA, the potential application of a shortened statute of limitations under section 340 may foreclose many claims.

\textbf{The Continued Viability of Medi-Cal}

Just as hospitals routinely are named in malpractice actions to ensure the existence of a "deep pocket,"\textsuperscript{100} so Medi-Cal will be named whenever possible. Plaintiffs will attempt to tie Medi-Cal into the causation chain to be assured of payment from the state if all other defendants are judgment proof. This predictable flood of litigation could result in consultants spending increased time away from their jobs at depositions and trials, and could compromise the effective administration of Medi-Cal.

The imposition of liability also may alter the decisional process of Medi-Cal consultants. Given the consultant's distance from the patient and the constant threat of liability, development of more elaborate means for consideration of treatment authorization requests may be necessary. This could require more extensive documentation by the treating physician, or direct communication between the


\textsuperscript{98} See supra note 94. \textsuperscript{99} See supra note 94. \textsuperscript{100} The "deep pocket rule" is a colloquial expression for the doctrine of joint and several liability. See The Fair Responsibility Act of 1986, \textsuperscript{99} \textsuperscript{99} \textsuperscript{99} \textsuperscript{99} CAL. CIV. PROC. CODE § 340.5(1) (West Supp. 1987); \textsuperscript{99} \textsuperscript{99} \textsuperscript{99} \textsuperscript{99} CAL. CIV. PROC. CODE § 364(f)(1) (West 1982).
treating physician and Medi-Cal consultant in each case. Either option could threaten the effective administration of the Medi-Cal system in light of current budget constraints and consultant workloads.101

Wickline also may cause consultants simply to approve more treatment requests. Such a deferral to the judgment of treating physicians completely would protect Medi-Cal from liability because no treatment request would be denied. Such unlimited approval, however, also would constitute a return to a system of retrospective utilization review and its attendant shortcomings.102

The imposition of third party payor liability impairs the fundamental purpose behind prospective utilization review and the Medi-Cal Act’s goal of providing adequate medical care to the indigent.103 Before Wickline, limited funds were used to provide essential medical care where it was needed most. After Wickline, these funds either may be diverted to increased administrative costs, or allocated under a retrospective disbursement system until exhausted prematurely.

Scope of Liability

The potential effect of Wickline is not limited to prospective utilization review. Prospective utilization review is only one of several cost containment mechanisms employed by third party payors of health care services.104 At the national level, Medicare recently switched to diagnosis-related groups (DRG’s) in response to a congressional mandate to develop a prospective rating system.105 DRG’s establish a pre-set rate of reimbursement for treatment of given medical conditions.106 A similar program also has been adopted in California, where contracting hospitals are paid an all-inclusive per diem rate regardless of the actual costs of treatment to individual patients.107

Under DRG-type systems, hospitals either lose money if the actual costs of treatment exceed the DRG reimbursement, or realize a profit if treatment is completed for less than the DRG reimburse-

101. Telephone interview with Robert M. Bartel, M.D., Former Medical Director, Computer Sciences Corporation, Medi-Cal Intermediary (Jan. 5, 1987).
102. Id.; See also supra note 14 and accompanying text.
104. See Note, supra note 16, at 1005.
105. Id.
106. Id. at 1005-06.
107. See generally Comment, California Negotiated Health Care: Implications for Malpractice Liability, 21 SAN DIEGO L. REV. 455 (1984); see also Peer Grouping Hospitals, supra note 11.
The common feature of each of these systems is that, like prospective review, the physician may be pressured to curtail treatment or discharge the patient prematurely. The Wickline court stated that, "it is essential that cost limitation programs not be permitted to corrupt medical judgment." Because over half of all physicians feel pressured by cost containment programs to undertreat or release patients early, Wickline suggests that third party payors may be exposed to an overwhelming degree of liability.

Private third party payors are not beyond the scope of liability. Recent California legislation authorizes private medical insurers to utilize cost controls in contracting with health care providers. The scope of potential third party payor liability established in Wickline virtually is unlimited, and may profoundly impact the health care industry.

THE EFFECT OF THIRD PARTY PAYOR LIABILITY ON PHYSICIANS

Because the ultimate concern of both the medical and legal systems is patient care, the most important aspect of third party payor liability will be its effect on physicians. If holding third party payors accountable for the results of their treatment authorization decisions improves the overall quality of patient care, then the imposition of such liability is best for all concerned.

Consider the example advanced by the court in Wickline. Suppose that, following the Medi-Cal consultant's initial decision, Wickline's treating physicians contacted the consultant and protested the denial of the four additional days of hospitalization. The court suggests that had Medi-Cal unreasonably ignored this protest, liability for any resulting injury to Ms. Wickline would have shifted conclusively to the state. This implies that Ms. Wickline's physicians would have

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108. See Note, supra note 16, at 1006.
109. See AM. MED. NEWS, supra note 2, at 17, quoting James H. Sammons, M.D., executive vice president of the American Medical Association:
    Reimbursement of hospitals by Medicare is currently based on the diagnosis related group (DRG) into which a patient's illness fits. This plan generally provides a particular level of payment for all patients with one DRG, regardless of differences in length of hospital stay. Thus, there may be an economic incentive for the hospital to limit the length of stay of any Medicare patient, and physicians may feel some pressure to discharge Medicare patients as soon as possible.
110. Wickline, 183 Cal. App. 3d at 1193, 228 Cal. Rptr. at 672.
111. See AM. MED. NEWS, supra note 2, at 17.
113. See supra note 33 and accompanying text.
been free to release her although fully cognizant of the attendant risk, while pointing to Medi-Cal as the liability scapegoat for the predictable injury.

Although such an analysis perhaps is logically appealing, it ignores the basic purpose of any health care system: patient care. It is inconceivable that a physician would stand by and allow a patient to be injured foreseeably, regardless of the third party payor's ultimate liability.

**CONCLUSION**

Medical cost containment mechanisms pressure physicians to undertreat or release patients prematurely. *Wickline* suggests that third party payors of health care benefits can be held accountable when the negligent design or implementation of cost containment mechanisms corrupts medical judgment and causes foreseeable injury. In government sponsored health programs such as Medi-Cal, a threshold question of governmental tort immunity exists. Although involving medical discretion, it seems unlikely that the decisional process of a Medi-Cal consultant rises to the level of a quasi-legislative policy decision that would invoke discretionary immunity.

More important than the question of third party payor liability is its potential impact on health care. Third party payors would receive different statutory treatment from other medical malpractice defendants. Although denied the protection of MICRA, third party payors would benefit from a shorter statute of limitations than is usual for medical malpractice actions. The imposition of liability also may cause third party payors to abandon cost controls altogether, which could lead to premature exhaustion of resources for medical care.

Because nearly half of all physicians feel pressured by cost containment mechanisms to release patients early, the scope of potential third party payor liability could be enormous. Medical malpractice plaintiffs will name both public and private third party payors wherever possible to ensure the existence of a solvent defendant. This predictable excess of litigation may pose additional administrative problems for third party payors, and channel scarce health care dollars away from treatment into legal costs.

The bottom line is whether third party payor liability will improve the overall quality of health care. This effect can be assessed only by a prediction of the impact of third party payor liability on individual physicians. Given a negligent and unreasonable denial of essential treatment benefits by a third party payor, a physician has two choices — either do nothing and allow foreseeable injury to the patient, or provide the essential treatment with little hope of payment. Ethical and logical concerns support the second alternative as the lesser of two evils.
First, the very essence of health care stands for the proposition that patient care always must come first, regardless of financial considerations. This is particularly true in situations where predictable injury can be prevented by appropriate intervention. Second, and perhaps more importantly, it is the physician, not the third party payor, who is closest to the patient and has the ability to prevent such injury. It contravenes medical ethics and the fundamental nature of the physician-patient relationship to suggest that a physician can allow a patient to be foreseeably injured.

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