BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against:	)	
JEANETTE YVETTE MARTELLO M.D.	)	MBC No. 17-2009-197045
Physician's & Surgeon's Certificate No. G 66298	)	
Petitioner.	)	

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Petitioner Jeanette Yvette Martello, M.D., and the time for action having expired at 5 p.m. on September 16, 2013, the petition is deemed denied by operation of law.

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against:	)	
	)	MBC No. 17-2009-197045
JEANETTE YVETTE MARTELLO, M.D.	)	
Physician's & Surgeon's Certificate No. G 66298	)	**ORDER GRANTING STAY**
	)	(Gov't Code Section 11521)
Respondent	)	

Respondent Jeanette Yvette Martello, M.D., has filed a Petition for Reconsideration of the Decision in this matter with an effective date of September 6, 2013.

Execution is stayed until September 16, 2013.

This stay is granted solely for the purpose of allowing the Board to review and consider the Petition for Reconsideration.

DATED: September 6, 2013

A. Renee Threadgill
Chief of Enforcement
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against:	)	
JEANNETTE YVETTE MARTELLO, M.D.	)	Case No. 17-2009-197045
Physician's and Surgeon's Certificate No. G-66298	)	OAH No. 2011090556
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 6, 2013.

IT IS SO ORDERED: August 8, 2013.

MEDICAL BOARD OF CALIFORNIA

Dev Gnanadev, M.D., Vice-Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against:	Case No. 17-2009-197045
JEANNETTE YVETTE MARTELLO, M.D.	OAH No. 2011090556
Physician's and Surgeon's Certificate No. G 66298,	
Respondent.	

PROPOSED DECISION

This matter was heard by Eric Sawyer, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, on October 22-25 and October 29-31, 2012, November 1, 2012, and April 4-5, 2013, in Los Angeles.

Cindy M. Lopez, Deputy Attorney General, represented Linda K. Whitney (Complainant).

Michael D. Gonzalez, Esq., represented Jeannette Martello, M.D. (Respondent), who was present each hearing day.

The record remained open at the conclusion of the hearing for the parties to remove from exhibit binders certain exhibits, or portions thereof, as well as redact confidential patient information from the remaining exhibits. The record was thereafter closed and the matter submitted for decision upon return of the exhibit binders on April 23, 2013. However, in reviewing the record, the ALJ discovered some exhibits were missing and some pages of exhibits that had not been admitted were included. The record was reopened and a teleconference held to discuss this situation on June 26, 2013. The parties agreed to submit the missing exhibits and a joint letter clarifying the status of the exhibit pages in question. The record was reclosed upon submission of those items on July 1, 2013. The ALJ sealed the exhibits containing confidential patient information in a separate order.

FACTUAL FINDINGS

Parties and Jurisdiction

1. Complainant is the Executive Director of the Medical Board of California (Board), which is within the Department of Consumer Affairs (Department).

2. On July 11, 1989, the Board issued Physician's and Surgeon's Certificate Number G 66298 to Respondent. The certificate was in full force and effect at all times relevant and will expire on February 28, 2015, unless renewed.

3. Complainant brought the Third Amended Accusation in her official capacity as the Executive Director of the Board. Respondent had previously submitted a Notice of Defense, which contained a request for the hearing that ensued, in response to the initial Accusation filed in this matter on August 2, 2011. By operation of Government Code section 11507, Respondent was not required to submit a new Notice of Defense in response to the amended accusations.

Respondent's Background

4. Respondent received her bachelor of science and master of science degrees from Stanford University in 1984, and her medical doctorate from the UCLA School of Medicine in 1988. She completed her surgical internship at Massachusetts General Hospital in 1989. She then completed a plastic surgery and general surgery integrated residency at the University of Kentucky Medical Center in 1995; she was chief plastic surgery resident in 1996. Respondent also completed a hand surgery fellowship at Kleinert & Kutz Institute of Hand Surgery in Kentucky in 1998.

5. Upon her return to California, Respondent worked in emergency rooms, and also started her own cosmetic and plastic surgery practice.

6. Respondent interrupted her medical training from 1989 to 1991 to attend law school at Boalt Hall at the University of California at Berkley. After later resuming her medical career, Respondent returned to Boalt Hall in 1996 and received a juris doctorate in 1997. It was not established whether Respondent has been admitted into the State Bar.

7. In 2001, Respondent became board certified in plastic and reconstructive surgery; she was recertified in 2010.

8. Respondent now has a private practice in South Pasadena. She is as an on-call specialist at several hospitals in Los Angeles County, particularly in San Gabriel Valley. The recent recession caused her cosmetic surgery practice to decrease. Most of her recent practice is spent on hand injury and emergency room consultations.

Patient K.T.

9. Patient K.T.[1] was a long time patient on whom Respondent had previously done abdominoplasty and liposuction without complication. Several years before that, K.T. had implants placed in both breasts by another surgeon.

[1] Initials are used to protect the privacy of the patients and their family members.

10. In May 2007, K.T. consulted with Respondent about breast surgery. K.T. was unhappy with how large were her breasts, and that they were sagging. Respondent testified that K.T.'s breast size at that time was probably a DD or DDD cup. K.T. wanted smaller breasts, in part, so she could buy regular size clothing "off the rack." K.T. told Respondent that she wanted her breasts to be a C or small D cup. K.T. also wanted her breasts to be more upright, rounded and perky. Respondent told K.T. that she could achieve those results. Respondent charged K.T. $10,540 for a breast lift with removal and replacement of her previously placed saline implants.

11. Respondent was concerned that K.T. may have a bleeding disorder, so she referred K.T. for a hematology consult; however, the results were unremarkable. Respondent also took other pre-operative precautions, including having K.T.'s physician vouch for her good health and requiring K.T. to take other screening tests. The results of the tests were unremarkable. Respondent also engaged in a thorough advised consent process with K.T. lasting several hours, in which Respondent explained the details of several pages of written consent forms she had previously sent to K.T. The consent forms listed a number of possible complications, including infection, scarring, skin break-down, tissue necrosis and death of the nipple areolar complex. Respondent cleared K.T. for surgery.

12. Respondent was provided insufficient information from K.T. regarding her prior breast implants. K.T. initially could not remember the plastic surgeon's name who did the procedure. The physician's last name she finally remembered was not helpful. K.T. had no paperwork or information regarding the size of the breast implants used. Respondent's office diligently checked all breast implant manufacturers but was unable to find information pertaining to her patient. However, K.T. advised Respondent that she thought her breast size was a "small A cup" prior to having implants. To deal with this situation, Respondent brought to surgery a number of different size implants to use after she opened K.T.'s breasts and determined the actual size of the existing implants.

13. On June 20, 2007, Respondent performed the surgery. She removed the existing implants, which had no serial numbers or markings, indicating they were not manufactured by an American company. The lack of information also made it difficult to determine the implants' size. By using sizers and draining one of the replaced implants, Respondent determined the replaced implants were 500 cubic centimeters (ccs). Respondent was also surprised that without implants K.T.'s breasts were much larger than a small A cup. Because the 450 cc implants Respondent initially wanted to use made K.T.'s breasts too large, she decided to use the smallest implants she had available, which were 400-430 ccs. Respondent also decided to remove some native breast tissue from the left breast to help reduce the overall breast size. She believed she could not take out any more native breast tissue for fear that doing so would compromise blood supply to the left nipple areolar complex. To gain the upright, rounded and perky effect K.T. wanted, Respondent also did the breast lift. Using breast implants was critical to that procedure. Respondent realized that after doing the breast lift, K.T.'s breasts were a full D cup rather than a full C or small D cup. Without the implants, K.T.'s breasts would still sag and not be shapely. Respondent did not believe a breast lift was possible without using the smallest size implant available to her.

14. It was not clearly and convincingly established that Respondent showed a lack of knowledge or otherwise improperly planned for this operation with regard to the size of implants available for the operation. Respondent reasonably relied on the information concerning the size of existing implants given to her by K.T., which was insufficient and proved to be erroneous. Respondent diligently tried to ascertain that information from other sources but was unable to do so. Respondent's expert witness on this topic, Dr. Thomas Toohey, persuasively opined that Respondent was adequately prepared for surgery without the precise information of the existing implant size by having several different implant sizes available at the time of the operation. Complainant's expert witness, Dr. Jeffrey Rosenberg, agreed on cross-examination that Respondent was diligent in trying to ascertain the existing implant size and that the lack of information was not an obstacle to going forward with the surgery.

15. On June 21, 2007, the day following the surgery, K.T. developed marked venous congestion of the left nipple areolar complex. This meant that the outflow of blood from K.T.'s nipple area was congested, which prevented new blood from coming into the area. This was a serious problem which, if not treated properly, could lead to tissue death of some of or the entire nipple.

16. Respondent immediately noticed and responded to this problem. She initially suggested removing the left implant to reduce pressure to the area, which she hoped would facilitate better blood flow. However, K.T. was extremely reluctant to have her new implants removed. She pushed Respondent for a more conservative approach. So Respondent removed sutures, and applied nitro paste and lidocaine to the area to improve blood flow. She also used medicinal leeches, which can induce blood flow by sucking out older blood pooled in the congested area.

17. Respondent's conservative approach was not successful. The venous congestion in K.T.'s left nipple area persisted. After discussing the situation with K.T., they decided to remove the left breast implant. K.T. was taken back to surgery and the left implant was removed on June 22, 2007. There were no symptoms of venous congestion in K.T.'s right breast nipple area at this time or any time.

18. It was not clearly and convincingly established that Respondent showed a lack of knowledge or otherwise placed too large of implants into K.T.'s breasts. It is true that after replacing the implants K.T.'s breasts were larger (a full D cup) than she had wanted (a full C but no larger than a small D cup). However, K.T. also wanted a breast lift, where her breasts would be upright, rounded and perky. Respondent determined that without using the smallest available implant such an effect was not possible; K.T. would have ended up with smaller breasts, but they would have still sagged and not been shapely. Respondent's expert witness, Dr. Toohey, persuasively opined that in such an instance, Respondent made an appropriate compromise in an effort to achieve both results. Complainant's expert witness, Dr. Rosenberg, did not effectively account for the fact that the patient had two goals in mind, not simply reducing her breast size by replacing the implants. Moreover, Dr. Rosenberg heavily based his opinion on the companion theory that the implants' size compromised the blood supply to the skin and nipple area and caused the venous congestion to the left nipple area.

However, that theory is not persuasive because K.T.'s right breast received the same size implant as the left and no sign of venous congestion was ever noted in the right nipple area.

19. Respondent continued using the leech therapy to combat the venous congestion through June 26, 2007. She observed marked improvement in the left nipple areolar complex, in that a pinkish color was gradually returning, which showed the congestion was reducing and blood circulation was improving. The venous congestion ultimately resolved, although a small part of the left nipple areolar complex was lost. Tissue necrosis in the nipple areolar complex is a common problem related to breast implant surgery and was discussed with K.T. during the advised consent process.

20. On June 26, 2007, after the leeching was completed, K.T. advised Respondent that she felt tired and was short of breath. In light of blood loss from the two past surgeries and the leeching, Respondent was concerned that K.T. may have a low blood count. Respondent advised K.T. to have her blood count checked immediately and she offered to take K.T. to a nearby ER. K.T. preferred going to Kaiser on her own. Later that day, K.T. was seen in the ER at Kaiser with hemoglobin of 6.3 and a hematocrit of 19.7, indicating a low blood count. The Kaiser ER was overloaded, so K.T. was admitted to the hospital and transfused with two units of blood. The low blood count resolved.

21. It was not clearly and convincingly established that Respondent failed appropriately to monitor K.T.'s postoperative-hemodynamic status, or that using leeches for five days caused the patient's blood count to go dangerously low. Respondent's expert witness on this topic, Dr. Ronald Sherman, persuasively opined that in 2007, there was no standard of care or protocol in the medical community requiring monitoring for anemia simply because medicinal leeches were used. Dr. Sherman also persuasively opined that leeches remove minimal amounts of blood, and that in K.T.'s case the use of leeching alone would not have required Respondent to refer K.T. out for blood count testing. Dr. Sherman also persuasively opined that in 2007, the standard of care simply required monitoring for anemia through assessment of standard symptoms, such as heart rate, blood pressure, pallor, shortness of breath, dizziness, etc. No evidence suggests K.T. displayed any of those classic symptoms until June 26th, at which time Respondent immediately recommended that K.T. have her blood count checked, and even offered to take her to the ER herself.

22. On July 12, 2007, Respondent noticed that the "T zone" on the right breast area was "starting to break down." The T zone is the anchor area on the bottom center of the breast where the implant was inserted; when the incision is sutured back together it forms an inverted T. That area later became infected. This was an area of concern described by Respondent during the advised consent meeting with K.T. because the T zone is a common problem area for delayed healing and infection after breast implant surgery.

23. On July 19, 2007, K.T. contacted Respondent's office and advised that she felt something "pop" and "flop" in her right breast. Later that day Respondent examined K.T. and determined that her right breast implant had fallen from its position down toward K.T.'s abdomen. Respondent was concerned about the lack of healing in the T zone area. She feared

that if the implant descended toward that wound, it could become exposed and lead to a serious infection. Respondent immediately recommended removal of the right implant. K.T. agreed. Respondent advised K.T. that after both breasts healed, she could try implants again.

24. On July 23, 2007, Respondent took K.T. back to surgery and removed the right breast implant. Respondent continued to follow K.T.'s progress and saw her during office visits. K.T.'s wounds later healed completely.

25. It was not clearly and convincingly established that Respondent showed a lack of knowledge when she did one surgery to remove the left implant, but did not remove the right implant at the same time, or that failure to have done so compromised the right breast. The left breast implant was removed as a last resort when more conservative approaches to the venous congestion in the nipple area were unsuccessful. There was no sign of venous congestion in the right nipple area. K.T. was extremely reluctant to have her new breast implants removed, and she only grudgingly gave Respondent consent to remove the left breast implant due to the venous congestion in the nipple area, which she was not experiencing in the right breast. Respondent had no consent to remove the right breast implant at that time. Respondent's expert on this topic, Dr. Toohey, persuasively opined that the standard of care only required recommending removal of the right implant. K.T. did not provide consent for that. K.T. did not experience problems with the right breast until one month later. Those problems related to the break-down of the incision and wound on the T zone of the right breast. Although the right breast implant later fell out of position, the cause of that was not established, and certainly not proven to be related to the failure to remove the right implant when the left was removed.

26. For the reasons explained above, it was not clearly and convincingly established that any of Respondent's above-described treatment and care of K.T. was beneath the standard of care.

Balance Billing Complaints

27. The Department of Managed Health Care (DMHC) is the state agency charged with enforcing the Knox-Keene Health Care Service Plan of 1975 (Knox-Keene Act). The Knox-Keene Act, located at Health and Safety Code section 1340 et seq., regulates health care service plans commonly referred to as health maintenance organizations, or HMO's. Health care service plans are required to cover an enrollee's (i.e., a patient's) emergency services, regardless of whether they are obtained from a network provider. A health plan is required to reimburse a non-network emergency care provider in an amount that is the reasonable and customary value of the services rendered.

28. Respondent has provided services at emergency rooms in Southern California, including those at Huntington Memorial Hospital (Huntington) in Pasadena and Providence St. Joseph Medical Center (St. Joseph's) in Burbank. These hospitals are required to provide emergency services to any person seeking emergency treatment, regardless of that person's ability to pay.

29. In some instances, a health plan's payment to a non-network emergency service provider will be less than the amount billed by the provider. In these cases, there is an outstanding unpaid balance of the provider's charges. In the specific cases discussed below, Respondent attempted to collect this unpaid balance from the enrollees. Such a practice is known as "balance billing." If the underlying service is emergency in nature, balance billing is illegal.[2]

30. Complainant contends that with respect to the five patients discussed below, Respondent provided emergency services and therefore was not allowed to seek or collect the balance from the patient. Respondent contends her services were not emergent in nature, but rather were cosmetic, which is not covered by the balance billing prohibitions. When Respondent did not receive full payment from the patients or their health plans, she filed civil lawsuits against them on her own behalf.

31. Some of the involved health care service plans sent letters to Respondent advising her that they believed she was engaging in illegal balance billing because the underlying services were emergency in nature. Respondent disputed the letters and advised the health care service plans that they were wrong.

32. The involved patients and/or their health care service plans began submitting complaints about both the balance billing and the lawsuits to DMHC. By a letter dated May 4, 2010, DMHC Staff Counsel Kyle C. Monson advised Respondent of his conclusion that she was engaging in illegal balance billing. Respondent spoke with Mr. Monson on the telephone on May 17, 2010, and sent him a letter the same day disputing DMHC's position. By a letter dated June 30, 2010, Staff Counsel Monson provided Respondent more detailed factual and legal explanations supporting his conclusion that her actions constituted illegal balance billing, and he again requested her to refrain from continuing to do so.

33. On December 30, 2010, DMHC issued a Cease and Desist Order (the Order) pursuant to Health and Safety Code section 1391, which ordered Respondent immediately to stop attempting to collect money from health plan enrollees who she saw in the emergency rooms for services rendered.

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[2] The California Supreme Court in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Ca1.4th 497 (*Prospect*), declared balance billing unlawful in the context of emergency medical care. When a health plan does not pay, in whole or in part, the amount charged by emergency room doctors, the doctors must resolve billing disputes solely with the health plans. The providers may seek dispute resolution, or even sue the health plans if they wish, but they may no longer bill patients with a health plan for the disputed amount. In addition, DMHC adopted a regulation, effective October 15, 2008, defining balance billing in the emergency care context as an unfair billing practice. (Cal. Code Regs., tit. 28, § 1300.71.39.)

34. The Order was served on Respondent by certified mail on December 30, 2010. According to the terms of the Order, it became effective immediately upon its issuance on December 30, 2010. Respondent received the Order on a date not established in the first few months of 2011, and she did not request a hearing to contest the Order or otherwise appeal it.

35. On or about July 13, 2011, DMHC filed a civil action against Respondent in the Superior Court of the State of California, County of Los Angeles, case number GC047718. On or after April 24, 2012, DMHC sought and obtained a preliminary injunction against Respondent prohibiting her from engaging in illegal balance billing. In support of its motion requesting injunctive relief, DMHC presented declarations from the patients and/or family members discussed in more detail below. Respondent timely answered the complaint and has asked the Superior Court to set aside the Order and/or the injunction. A trial in that matter has been scheduled, but as of the hearing of the instant administrative matter, the trial in Superior Court had not yet commenced.

Patient S.M.

36. S.M., a 20-year-old female, was involved in a serious car accident on October 31, 2009. She sustained serious injuries to her face and body and was brought into the emergency room at Huntington. At the time, S.M. was covered by her parents' health insurance policy with Health Net. However, Health Net did not have a contract for services with Huntington. S.M. was intubated and admitted to the Intensive Care Unit (ICU) by the trauma surgeon who saw her in the ER. CT scans revealed she had multiple facial fractures, including near her orbital area, as well as a left femur fracture, among other injuries.

37. The trauma surgeon requested a plastic surgery consultation by Respondent, given the facial swelling and multiple facial fractures noted on CT scans. Respondent performed a maxillofacial examination and evaluated S.M. in the ICU. At that time, S.M. was in a medically induced coma. Respondent noted a bony fracture possibly impinging on the optic nerve. Respondent recommended an ophthalmology consultation. During this time, S.M.'s blood pressure dropped rapidly. Respondent had to resuscitate S.M.

38. Respondent spent over an hour on the telephone locating S.M.'s family members to discuss the facial fractures, including the bony fracture possibly impinging on the optic nerve. S.M.'s parents later arrived at the ICU. Respondent had S.M.'s parents read and sign an agreement to accept full financial responsibility whether or not their insurance paid any portion of her bills.

39. S.M. stayed at Huntington until November 3, 2009, when she was transferred to USC University Hospital (USC) for insurance purposes. The transfer occurred after she was examined by Respondent. S.M.'s father declared in the Superior Court proceedings that she was transferred once Huntington staff deemed her stable enough to do so. Surgery was later done at USC to repair the facial fractures, including a number of metal plates being inserted on her skull.

40. On or about February 21, 2010, Respondent submitted bills totaling $1,850 to Health Net, through Regal Medical Group (Regal), for services rendered to S.M. In those bills, and in other documents she submitted, Respondent described the services as "emergency plastic surgery consultation and other miscellaneous emergency services including critical care time." Respondent depicted her services as emergent in nature, including statements that S.M.'s facial fractures were "unstable," that Respondent requested an emergency ophthalmology consultation due to concern over possible impingement by a bony spicule near the orbital area, and her "emergency critical care time" including her efforts to revive S.M. when her blood pressure fell to "shock level." Respondent also described how her prior trauma and emergency room experience allowed her to comfortably respond "in emergently evaluating and treating" S.M. In another document, Respondent noted that from "a maxillofacial standpoint, the patient has to be stabilized from a trauma standpoint and have her cervical spine cleared before operative repair of the multiple facial fractures is entertained."

41. According to Becky Nething, a claims representative of Regal, Respondent's bills were received on or about May 17, 2010, and treated as claims for emergency medical services by an out-of-network provider based on the codes Respondent used and the information she submitted. Regal issued Respondent a payment of $133.57 as the reasonable and customary value of her services provided to S.M. On or about February 9, 2011, Respondent resubmitted the previous bills and asked Regal to pay the entire amount. She also returned what Health Net had previously paid her.

42. On or about February 8, 2011, Respondent sent a letter and bill for $2,900 to S.M.'s parents. Included in the bill was a charge for $750 for "social work/phone calls to locate family for 1 ½ hours." Respondent advised S.M.'s parents that she had only billed Regal and/or Health Net as a courtesy, and that she expected payment of the full amount from them. S.M.'s father, who is an attorney, conducted legal research and concluded that the aforementioned *Prospect* case prohibited Respondent from collecting any amount not paid by Health Net. S.M.'s father refused to pay any part of Respondent's bill. An acrimonious e-mail exchange ensued between the two.

43. On May 6, 2011, Respondent filed a civil lawsuit against S.M.'s parents for damages of $2,900. She alleged S.M.'s parents breached the agreement they signed on behalf of S.M., as well as causes of action for fraud and a request for punitive damages. S.M.'s father represented the family. On October 19, 2011, the lawsuit was dismissed because the court concluded that Respondent violated the Order that had been issued in December 2010. Respondent's appeal was denied and the matter became final.

Patient J.S. (an Adult)

44. J.S. is an adult woman who had health insurance through CIGNA. On November 14, 2009, she had been drinking at home and had a serious fall. She either tripped over something or passed out. She landed on her face and suffered serious injuries, including

a concussion, fractured nose, and a large through-and-through tear of her upper lip to below her nose. She was taken to the emergency room at St. Joseph's by a friend. CIGNA did not have a contract for services with St. Joseph's.

45. J.S. was evaluated and provided emergency room care and treatment by an emergency room physician, who requested a plastic surgery consultation. The ER physician, Dr. Toth, did not want to do the repair to the torn lip area. Hospital records from ER personnel describe the wound as a "severe/complex full-thickness laceration to the lip." J.S. told ER staff that she was concerned about scarring. ER staff contacted five plastic surgeons, but each declined because J.S.'s medical service provider, Lakeside Medical Group (Lakeside), was rumored to be going bankrupt. By now, J.S. had been moved to the "fast track" area of the ER, where less acute ER patients are seen, and had been joined by her sister. The process of contacting plastic surgeons took several hours. J.S. and her sister complained about the delay. J.S. was told that a physician assistant could stitch her torn lip back together or that she could go to a county hospital. J.S. declined and awaited a plastic surgeon.

46. Respondent arrive over five hours after J.S. came to St. Joseph's. She was the sixth plastic surgeon contacted by ER staff. Respondent had J.S. read and sign an agreement to accept financial responsibility for any portion of her bills not paid by her insurance. J.S.'s sister, who is an attorney, reviewed the agreement before J.S. signed it.

47. Respondent took a history from J.S. and learned that she had been drinking and may have fainted. Respondent decided to evaluate J.S. for possible syncope and collapse, a potentially serious problem. Respondent ordered several blood and urine tests, as well as brain and facial CTs. J.S. was also hooked up to an EKG monitor. The test results were negative, except that J.S. had a .124 blood alcohol concentration which suggested the fall could have been related to her alcohol consumption. Respondent performed surgery in the ER area, which she described in her operative report as "complex closure of external upper lip laceration across vermilion border [and] complex closure of intraoral lip and mucosal laceration." J.S. had the stitches removed days later at Respondent's office.

48. On or about May 21, 2010, Respondent submitted bills totaling $10,250 to Lakeside for her services rendered to J.S. Respondent also sent a letter to Lakeside describing the services she rendered as "emergency plastic surgery consultation and emergency plastic surgery." In that letter, Respondent also detailed how the ER physician, Dr. Toth, did not feel comfortable suturing this "complex, severe upper lip laceration since there was a gaping hole in the middle of her [J.S.'s] face." Respondent also stated that the case was made more difficult and unusual because J.S. had been drinking, she bled and oozed more easily and she was emotionally unstable. Respondent also detailed how she had to take time to irrigate all of her wounds with antibiotics, and that she needed to borrow special instruments from an operating room to help her with the surgery. Respondent concluded that J.S. was seen "on an emergency basis," and that she was the only plastic and reconstructive surgeon who responded "to the emergency need."

49. Becky Nething, a claims representative of Regal, is familiar with the medical billing of J.S. because CIGNA has delegated such tasks to Regal. Ms. Nething testified that Respondent's bills to J.S. were received and treated as claims for emergency medical services by an out-of-network provider based on the codes Respondent used and the information she submitted. CIGNA paid Respondent $1,431.51 as the reasonable and customary value of her services. CIGNA documents indicate that Respondent disputed those payments by no later than June 2010, but it was not established that the dispute process was fully used or concluded. Instead, Respondent sent a bill to J.S. on or about October 6, 2010, in which she charged the difference between what she billed to Lakeside and what she received, i.e., $8,818.49. However, Respondent made J.S. a one-time offer to reduce her bill to $7,500 if she paid it by a certain deadline. J.S. declined to pay any amount, having been advised by CIGNA that she was not responsible for Respondent's charges.

50. In November 2010, a Lakeside employee advised Respondent that she believed Respondent was engaging in illegal balance billing. She asked Respondent to cease collection activity against J.S., but also indicated that Lakeside was willing to pay her 65 percent of the amount she billed. Respondent disagreed and rejected the offer. A staff attorney from CIGNA became involved in an e-mail dialogue with Respondent. He advised her that he also concluded she was illegally balance billing. Respondent disagreed. The communication between these parties was acrimonious.

51. In February 2011, Respondent mailed checks to Lakeside totaling what she had received in payment from CIGNA. In April 2011, Respondent sent e-mails to J.S. demanding payment of her entire bill, i.e. $10,250. J.S. refused to pay.

52. On May 9, 2011, Respondent filed a lawsuit against J.S. and her sister seeking $10,250. She alleged that J.S. and her sister had breached the agreement J.S. signed and that they had defrauded Respondent. J.S. testified that she was represented in that lawsuit by her sister. Respondent dismissed the lawsuit on December 30, 2011.

Patient J.S. (a Minor)

53. On January 4, 2010, J.S., an 18-month-old male, was playing at home with his twin brother. J.S.'s brother pushed him down and J.S. landed on his face. One or two teeth punctured his lip from the inside and left a visible wound on the outside. He began to bleed profusely. At the time, J.S. was covered by his parents' health insurance through Anthem Blue Cross (Blue Cross). J.S.'s father called his family doctor's office. He was advised to take J.S. to the emergency room and to ask for a plastic surgeon. J.S. was taken to the ER at Huntington, which does not have a contract for services with Blue Cross.

54. J.S. was evaluated and treated by an ER physician. A plastic surgery consultation was requested due to the parents' concern about possible scarring. Respondent provided the plastic surgery consultation and repaired the lower lip lacerations.

55. Before rendering services, Respondent had J.S.'s parents sign an agreement to accept full financial responsibility for his medical care, whether or not their insurance paid any portion of the bill. J.S.'s father reviewed it quickly, but did not focus on it.

56. On or about January 24, 2010, Respondent submitted claims to Blue Cross totaling $2,445. On top of the claim forms, Respondent wrote "emergency plastic surgery consultation." In documents Respondent also submitted to Blue Cross to justify her claims, she described her services as "emergency plastic surgery consultation" and "emergency plastic surgery services." Respondent described J.S.'s injury as a "through and through right lower lip laceration that includes involvement across the vermillion border externally." She also indicated that there was another lip laceration internally. Respondent explained that the wounds were thoroughly irrigated with sterile saline and antibiotics, after being explored to determine no teeth fragments were present. In another document, Respondent described how the ER physician, Dr. Kalter, realized the wounds were more extensive than he could treat, so she was "emergently consulted . . . to emergently evaluate and treat" the patient. She also explained that she was the only plastic and reconstructive surgeon on call, no Blue Cross contracted providers were available and that "his [J.S.'s] condition could not wait."

57. Jesse Burke of Blue Cross testified that Respondent's claims were received by Blue Cross and accepted as claims for emergency services of an out-of-network provider, based on the codes used and the language inserted on the claims by Respondent. Blue Cross paid Respondent $616.20 as the reasonable and customary value of her services. On or before March 8, 2010, Respondent sent a bill to J.S.'s parents demanding $1,040 for the balance of the bill. Respondent indicated that she would waive the rest of the bill if it was paid at that time. J.S.'s parents paid $1,040 by credit card. However, one of the parents later contacted Blue Cross to ask about the bill and was advised that Respondent should not have charged them at all. The parents were instructed to ask Respondent for a refund. One of the parents called and asked Respondent for a refund, but Respondent refused, telling the parent that her bill was not prohibited by California law. By a letter dated April 19, 2010, Mr. Burke advised Respondent that she improperly balance billed J.S.'s parents, requested her to reimburse them the amount they paid, and reminded her that she could pursue an internal appeal with Blue Cross for additional payment. By or about this time, J.S.'s parents disputed the credit card payment they made to Respondent and received a refund of that amount.

58. Subsequently, either J.S.'s parents and/or Blue Cross submitted a complaint against Respondent to the DMHC. Respondent returned the $616.20 she had received from Blue Cross on or about February 13, 2011. Respondent sent a new bill to J.S.'s parents for the full amount of $2,445. The parents refused to pay, based on the advice they received from DMHC.

59. In June 2011, Respondent filed a civil complaint against J.S.'s parents for the full amount of $2,445. Respondent alleged that J.S.'s parents breached the agreement with her they signed and defrauded her by requesting a refund of their credit card payment. The parents hired an attorney to represent them in that lawsuit. J.S.'s father testified the lawsuit has been stayed.

Patient C.B.

60. C.B. is a married adult male. He is a self-employed custom cabinet maker. On April 27, 2010, he had an accident in his shop during which he amputated part of one finger of his left hand and suffered a severe cut on another part of the same hand. At the time, C.B. was a member of Blue Cross through his wife's health insurance policy. He first went to an emergency room in Irwindale, but it was closed. His wife picked him up and took him to the ER at Huntington, which did not have a contract for services with Blue Cross.

61. C.B. was seen by an ER physician. Respondent was called to consult and she arrived in less than an hour to evaluate C.B.'s condition. During that process, she told C.B. about her hand surgery experience, including that she was a member of the team that performed the first hand transplant in Kentucky. Respondent advised C.B. that he needed surgery. However, C.B. was dehydrated and she did not want to operate on him until he could be hydrated. Respondent had C.B. admitted to the hospital. While in the ER, Respondent required C.B. and his wife to sign an agreement to accept full financial responsibility for his care whether or not his insurance paid any portion of the bill.

62. Respondent performed surgery on April 28, 2010. She successfully repaired C.B.'s left hand, including flap and tissue rearrangement coverage for the left small finger amputation and repair to the laceration on his hand. On a discharge document she wrote on April 29, 2010, Respondent described C.B.'s treatment as "emergency surgery & IV antibiotics." Thereafter C.B. visited Respondent's office on a few occasions for routine wound care.

63. On or about May 19, 2010, Respondent submitted claims to Blue Cross totaling $15,130. On top of the claim forms, Respondent wrote "emergency hand surgery consultation" and "emergency hand surgical services." In documents Respondent also submitted to Blue Cross to justify her claims, she described her services similarly. She also described her extensive experience as a hand surgeon and in answering calls to the ER. She stated C.B.'s service was an "emergent hand surgery . . ." Respondent explained that the situation involved unusual circumstances because C.B. needed to be hydrated and his hand warmed to increase blood circulation, which was essential to a successful outcome. She described the patient's long-term smoking also made "this surgery even more tenuous and unusual." Respondent reported that the ER physician who saw C.B. noted his injury was "devastating" and asked Respondent to consult. She also reported that no other Blue Cross hand surgeon was available and that she was the only hand surgeon on call at the time. Respondent explained in great detail how C.B. was a left-handed custom cabinet maker and how this serious injury to his left hand could impact his livelihood. Respondent also described how she had to thoroughly clean the wounds with antibiotics to prevent flesh-eating bacteria and other serious infections from developing. She concluded that "emergency hand surgery consultation and emergency hand surgical services had to be performed by me for these devastating left hand injuries which required emergency attention be performed by a uniquely and well qualified hand surgeon specialist such as myself."

64. Jesse Burke of Blue Cross testified that Respondent's claims were received by Blue Cross and accepted as claims for emergency services of an out-of-network provider, based on the codes used and the language inserted on the claims by Respondent. Blue Cross paid Respondent $3,503.51 as the reasonable and customary value of her services. On or about June 10, 2010, Respondent sent a bill to C.B. and his wife for the balance of her bill not paid by Blue Cross. Neither C.B. nor his wife paid any amount to Respondent. They had been in contact with Blue Cross and were informed they were not required to pay Respondent's bill. At some point, C.B. and/or his wife complained about Respondent to DMHC, which in turn referred the matter to Blue Cross. Mr. Burke got involved at that time. By February 26, 2011, Respondent returned the $3,503.51 she had received from Blue Cross.

65. On December 30, 2010, Respondent filed a civil complaint for $12,627.50 against C.B., his wife and their company for breach of contract. For reasons not established, C.B. filed an answer on his behalf, but an answer was not filed for his wife. On or about May 4, 2011, Respondent obtained a default judgment against C.B.'s wife for $14,214.20. Respondent dismissed the case against C.B. and his business. On or about July 22, 2011, Respondent attempted to enforce the default judgment by obtaining an order to sell the family's home. C.B. and his wife hired an attorney, who was able to stop the judgment sale of their home and who is attempting to set aside the default judgment. C.B. testified that some or all of Respondent's legal actions have been vacated but that Respondent has appealed.

Patient S.A.

66. On August 14, 2010, patient S.A., an 11-year-old girl, was bitten in the face by a dog. She sustained a serious laceration to her upper lip and was bleeding profusely. The owner of the dog called 911 and an ambulance was dispatched. S.A. was taken to the Urgent Care section of the Huntington ER. S.A. was covered through her parents' health insurance policy with Kaiser, which did not have a contract for services with Huntington.

67. S.A. was seen by the ER physician, who stopped the bleeding. Respondent was called to provide a plastic surgery consultation. In less than 60 minutes, Respondent arrived and evaluated S.A. Respondent spoke with the patient's mother and recommended surgery to close the wound. At some point, but before rendering services, Respondent had S.A.'s mother sign an agreement to accept full financial responsibility whether or not their insurance paid any portion of the bill.

68. At or about the same time, Respondent learned that S.A. was a Kaiser member. Respondent contacted Kaiser and advised a Kaiser official that S.A. was stable for transfer to a Kaiser Hospital for wound closure by a Kaiser plastic surgeon. S.A.'s mother had earlier expressed her preference that S.A. be treated at Huntington as opposed to Kaiser. The Kaiser physician gave Respondent authorization to perform the plastic surgery procedure at Huntington and provided Respondent with a Kaiser authorization number. S.A.'s mother was advised that Kaiser had given Respondent authorization to perform the procedure. Respondent performed the surgical closure of the facial laceration and scheduled

follow up with the patient and her mother in her office. In her operative report, Respondent described her procedure as a "complex closure." A photograph taken of her before Respondent's procedure shows S.A. had a deep chunk of flesh taken out of her lip.

69. On April 4, 2011, S.A. and her mother visited Respondent's office for a follow-up. During that visit, S.A.'s mother advised Respondent that she had retained an attorney to seek damages from the owner of the dog that had bitten her daughter in the face. For reasons that are not clear, Respondent became gravely offended by that course of action. In an office note written at or about the time of that visit, Respondent states that she had decided to not send her bill to Kaiser for fear of engaging in insurance fraud if she did so. Her reasoning in arriving at that conclusion is not clear, nor does it now seem reasonable. In any event, and for whatever reason, on April 24, 2011, Respondent sent a bill for the first time to S.A.'s mother totaling $9,000. S.A.'s mother advised Respondent that she could not afford to pay the bill, but that she wanted to submit it to Kaiser for payment. Over the next few days, Respondent's office pressed S.A.'s mother to pay the bill. When S.A.'s mother asked for the Kaiser authorization number Respondent obtained when she called Kaiser from the ER, Respondent's office told S.A.'s mother to get it herself from the medical records at Huntington. S.A.'s mother did not pay Respondent's bill, but she did send it to Kaiser.

70. In a letter dated May 18, 2011, Respondent advised Kaiser of her fear that S.A.'s mother was engaged in insurance fraud, and stated that she would not send Kaiser a bill for her services for that reason. In later correspondence, Kaiser staff seemed unimpressed by Respondent's concern.

71. On June 3, 2011, Respondent filed a civil lawsuit against S.A.'s mother for damages in the amount of $9,000. She alleged S.A.'s mother breached the agreement Respondent had her sign, and committed fraud. The attorney S.A.'s mother retained to sue the owner of the dog represented S.A.'s mother in Respondent's case. That attorney advised Kaiser that Respondent had sued S.A.'s mother and he asked Kaiser to defend and indemnify her against Respondent. DMHC was also made aware of the situation. The civil case was stayed pending the outcome of the DMHC lawsuit.

72. By April 2012, Kaiser paid Respondent the full amount of her bill. Debbie Davis, a Kaiser employee, testified that Kaiser had authorized Respondent to perform emergency services at Huntington and that Kaiser paid Respondent's bills when they were first presented to Kaiser. S.A.'s mother testified that the lawsuit against her by Respondent was dismissed.

False Billing Claims

73. On or after May 21, 2010, Respondent submitted a 1500 Health Insurance Claim Form (HICFO) to Lakeside entitled "Emergency Plastic Surgery Consultation" for services she provided on November 14, 2009 to J.S. (the adult). On this same date Respondent submitted a HICFO with Lakeside entitled "Emergency Plastic Surgical Operative Services" for services she provided on November 14, 2009 to J.S. (the adult).

Respondent also submitted a document entitled "Submitted by Dr. Jeanette Martello, Board Certified Plastic and Reconstructive Surgeon and out-of-network provider" for services rendered to J.S. on November 14, 2009.

74. On or about January 24, 2010, Respondent submitted the following documents to Blue Cross for services rendered to patient J.S. (the minor) on January 4, 2010: a HICFO entitled "Emergency Plastic Surgery Consultation;" a HICFO entitled "Emergency Plastic Surgical Procedure;" and a letter addressed to Blue Cross dated January 24, 2010 explaining the services she provided to patient J.S. (the minor) on January 4, 2010.

75. On or about May 19, 2010, Respondent submitted the following documents to Blue Cross for services rendered to patient C.B. on April 27 and 28, 2010: a HICFO entitled "Emergency Hand Surgery Consultation;" a HICFO entitled "Emergency Hand Surgical Services;" correspondence entitled "Emergency Hand Surgery Consultation;" and another correspondence entitled "Emergency Hand Surgery Consultation and Operatives Services;" explaining the services she provided to patient C.B. on April 27 and 28, 2010.

76. On or about May 17, 2010, Respondent submitted the following documents to Regal for services rendered to patient S.M. on October 31-November 3, 2009: two HICFOs entitled "Emergency Plastic Surgery Consultation;" a HICFO entitled "Emergency Critical Care Time;" a document entitled "Emergency Plastic Surgery Consultation;" and a document entitled "Emergency Plastic Surgery Consultation and Other Miscellaneous Emergency Services Including Critical Care Time."

77. During the hearing of this matter, Respondent testified that she did not provide any emergency service to any of these four patients, but that instead she performed elective cosmetic consultation and/or surgery services. Specifically, Respondent testified that she did not intend to convey to the insurance companies by her documents that her services were emergent in nature, and that she added the above-described extraneous language to those documents simply to convey that she had been called away from her office to see a patient in the hospital. She also testified that at the time she created and submitted the documents in question, she had not done any legal research regarding the definition of "emergency services," but that legal research she later performed revealed to her that she had not provided emergency services. Respondent testified that the CPT codes she used on the HICFOs denoted only the procedures she used and that they occurred in the setting of an emergency room, not that they were emergent. Otherwise, Respondent testified that she believed her services were cosmetic.

78. The Third Amended Accusation was filed after, and in response to, Respondent's above-described testimony. It added two new causes of discipline alleging that in light of Respondent's testimony, the above-described documents she submitted to the insurance companies contained false billing information, inasmuch as they appeared to bill for emergency services while Respondent testified she only provided cosmetic services.

79. It was not clearly and convincingly established that Respondent knowingly made and signed the above-described documents to falsely represent the existence or nonexistence of a state of facts related to her practice of medicine. In fact, it was established that, at the time Respondent submitted the documents in question to the various insurance companies, she believed her services were emergent in nature and were not cosmetic. Under these circumstances, it cannot be concluded that she knowingly submitted documents containing false information.

80. Respondent's testimony that she did not submit bills for emergency services was unbelievable. Her admission that she had not conducted any legal research regarding the definition of emergency services by or before the time she created and submitted the documents in question only supports the conclusion that she was of the opinion at the time that she had responded to emergent situations and had provided emergency services. Respondent's testimony that it was her practice to include the phrases "emergency plastic surgery consultation" and/or "emergency plastic surgical procedure" on HICFOs for any service done after being called away from her office was uncorroborated and self-serving. The HICFOs and the other documents Respondent submitted to the insurance companies to justify her bills clearly describe dramatic situations, complex injuries and treatments, and unusual circumstances that were emergent in nature. Respondent's testimony does not account for those explicit descriptions. Every insurance company that processed her bills uniformly treated them as for emergency services without question. Respondent's testimony that the services she provided were purely cosmetic is belied by the complete absence of any words, phrases or information in any of the documents she submitted to the insurance companies giving any indication that the services were cosmetic. In fact, Respondent testified that she knew at the time that insurance companies did not pay for out-of-network cosmetic services. It is not plausible for her to have submitted such bills to insurance companies knowing that they would not pay for cosmetic procedures.

81. The expert witness testimony of Wendy Britton-Knua did nothing to alter the above findings. Though her testimony that Respondent's bills submitted to insurance were not false or fraudulent was credible and supported by the evidence, she established little more than that. She is not a physician and has little experience regarding California health care law. Her opinions supporting Respondent's testimony described above were not persuasive. For example, she testified that the HICFOs in question did not per se depict emergency services and that it was an industry standard to leave box 24C of the HICFO blank unless the bill was for emergency services (Respondent left box 24 C blank). However, that testimony was undercut by the insurance claims representatives who testified in this case that box 24C is rarely filled out in any circumstance; and from Respondent's testimony where the only specific example of a condition in which she would mark box 24C would be a case of flesh eating bacteria. In any event, all of the involved insurance companies uniformly treated Respondent's bills as requesting payment for emergency services, which indicates that Ms. Britton-Knua has a tenuous grasp of industry standards, at least in California.

Other Evidence Relevant to Balance Billing

82. Complainant's expert witness, Dr. Andrea Brault, an expert in the field of emergency services and the owner of a billing service, persuasively opined that all five patients involved in the balance billing cases had emergency medical conditions. Dr. Brault explained that an emergency medical condition is an acute condition which requires medical treatment to prevent serious injury to body parts or organs. Dr. Brault opined that if Respondent had not closed the wounds involved in most of these cases, there would be significant risk of infection, and serious dysfunction to the face or hand. She explained that a patient is stabilized when the wound is closed; so while that wound remains open, the emergency medical condition continues. She also explained that in the case of S.M., she had sustained serious injuries that were still being evaluated and discovered in the ICU, including by Respondent, who found a possible impingement on the optic nerve by a bone spicule, and that the patient was far from stabilized. Dr. Brault's testimony is bolstered by Respondent herself, who as discussed above, characterized these situations as emergencies on records she created and documents she sent for billing purposes. Dr. Brault's testimony was also supported by the testimony of the involved patients or their parents, who reasonably believed, based on the injuries that they or their children sustained, that they needed to visit the emergency room and that the services they received there were emergent in nature.

83. On the other hand, Respondent's expert witness on this topic, Dr. John Levin, was not persuasive. Dr. Levin is board certified in emergency room medicine and has practiced in that field for several years. He opined that none of the five patient cases involved an emergency medical condition by the time that Respondent treated them because they had already been stabilized by ER personnel. Dr. Levin's opinion was obviously undercut by the way in which Respondent herself described the situations and her services in the documentation she created regarding these cases. Moreover, Dr. Levin had to admit that many of these cases were at least "urgent." Dr. Levin based his opinions on the belief that the services Respondent rendered could have been performed by ER personnel or that the patients in question could have simply gone home and visited Respondent in her office the following day to receive the same service. Yet, that opinion is undercut by Respondent's comments in her paperwork that ER personnel either did not feel comfortable performing the services in question or that she was the only one qualified to do so. Moreover, Dr. Levin had to admit that no patient with a hole in their lip or an amputated finger would be sent home without having those wounds closed. Respondent closed those wounds, after cleaning them to prevent infection and, in some cases, evaluating whether other damage had been done. In addition, Dr. Levin testified that Respondent simply performed cosmetic services. He later admitted that cosmetic surgeries are typically planned in advance and involve making an existing body part look better; in these cases, the medical services were certainly not planned, and they involved repairing seriously damaged body parts, factors which are inconsistent with cosmetic surgery.

84. The involved patients or their parents signed agreements Respondent gave them accepting financial responsibility for her services, regardless of insurance payments. However, the involved signors uniformly testified credibly that they did not remember reading or signing the document; except for C.B., who simply testified that he and his wife

signed the agreement. However, it would not be expected that the patients or their parents spent any meaningful time reviewing Respondent's form under the circumstances. Medical records from Huntington and St. Joseph's reveal that Respondent's form was just one of many other documents the patients or their parents were asked to sign. The patients, or the parents of the minor patients, were still in the midst of the trauma and stress from the involved injuries when Respondent asked them to sign her agreement. At no time did Respondent advise the patients or their parents of the costs for her proposed services. Respondent testified that it is her practice to speak only of clinical issues and to have her staff discuss financial details with patients. Moreover, at no time did Respondent engage in any meaningful discussion with the patients or their parents in which she advised them that her services were cosmetic and that there would be little or no chance of their HMOs paying her bills. Stated another way, the involved patients or their parents had no understanding that they would be likely to receive a significant bill from Respondent and that their HMOs would not pay for all or most of Respondent's services.

85. As established by the declarations of Jesse Burke and Becky Nething submitted in the Superior Court litigation concerning the Order, as well as the testimony of Mr. Burke, Ms. Nething, and Debbie Davis, it was clearly and convincingly established that the insurance policies covering the five involved patients were, and are, HMOs. No evidence was presented indicating that any of the five insurance policies in question were self-funded. To the contrary, the evidence clearly and convincingly established that these were traditional health insurance policies either purchased by the patients' employers, or by their parents' employers, or were individually purchased directly by the patient from an HMO.

86. Respondent may have filed initial claim disputes or advocated for additional compensation for the claims she submitted to the involved insurance companies, but it was clearly and convincingly established that she never completed or exhausted any internal complaint or dispute mechanism available through any of the involved insurance companies.

Mitigation, Aggravation & Rehabilitation

87. Mitigation. Respondent has no prior record of disciplinary action with the Board. Her technical skill as a plastic and reconstructive surgeon is without question. She has excellent schooling, training and prior experience. Her plastic surgical results for patients J.S. (the adult), J.S. (the minor), C.B., and S.A. were excellent, as attested to by those patients or their parents. She discovered problems for patient S.M. that slipped past ER staff and she was there to resuscitate S.M. in her moment of need when her blood pressure crashed. She cannot be blamed for what happened to patient K.T.; nonetheless, Respondent quickly, decisively and maturely responded to all of the complications that arose with K.T., which probably prevented her situation from becoming worse.

88. Aggravation. The following aggravating facts were established:

A. Through her aggressive collection efforts, including litigation, Respondent caused the involved patients to expend significant amounts of time and money communicating with their insurance companies and hiring lawyers to defend against her

claims. The involved patients and/or their responsible family members suffered emotional stress responding to Respondent's collection efforts. To make matters worse, Respondent so far has not prevailed in any of those lawsuits.

B) Respondent's testimony in this case regarding her state of mind when she submitted the HICFOs for the four patients discussed above was not truthful. It was clearly and convincingly established that she believed she was responding to emergent situations and provided emergency treatment when she prepared those billing documents. While she may have later conducted her own legal research and convinced herself after-the-fact that she had not provided emergency services, such does not excuse her from falsely testifying in this case that she initially intended to bill only for cosmetic services. Her candor in this important respect was expected, particularly as she is a person trained in both medicine and the law. Her false testimony in that regard also undercut her credibility in other areas pertaining to the balance billing issues.

C) Respondent was evasive and vague in her testimony regarding when she was served with and/or received the Order. She admitted that she received it sometime in 2011, but she testified that she does not remember how or when she got it. She vaguely testified that she had been travelling early in 2011, but she offered no specifics. Respondent's testimony was self-serving and uncorroborated. Her testimony was also not credible. As an attorney, it is assumed the receipt of a legal document such as the Order would have had greater impact on her memory. In other areas where it served her interest, Respondent provided great detail and specifics in her testimony, even as to events which occurred far earlier than 2011 (such as those pertaining to patient K.T.). Even giving Respondent the benefit of the doubt that she had not received the Order until April 2011 (stretching "early 2011" to the breaking point), she still took actions in violation of it thereafter. For example, in May 2011 she filed her lawsuits against S.M.'s parents, as well as J.S. (the adult) and her sister. In May 2011, she also began her efforts to collect on the default judgment against C.B.'s wife. In June 2011, she filed her lawsuit against J.S.'s (the minor's) parents, and she filed her lawsuit against S.A.'s mother.

89. Rehabilitation. Of concern is the complete lack of remorse or contrition expressed by Respondent. She has failed to accept even a scintilla of responsibility in any regard. Respondent presented no evidence indicating that she has engaged in any degree of retrospection, introspection or rehabilitation. Based on the record presented in this case, there is no doubt that if the status quo remains, Respondent will in the future engage in exactly the same behavior regarding balance billing and collections from her patients.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. The burden of proof is on Complainant to establish the charges by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 855-856.)

Causes of Discipline Regarding Patient K.T.

2. Cause of Discipline for Incompetence. Respondent is not subject to disciplinary action under Business and Professions Code section 2234, subdivision (d),[3] in that it was not clearly and convincingly established that she demonstrated a lack of knowledge or skill in discharging professional medical obligations in treating patient K.T. (Factual Findings 8-26.)

3. Cause of Discipline for Repeated Negligent Acts. Respondent is not subject to disciplinary action under section 2234, subdivision (c), in that it was not clearly and convincingly established that Respondent committed repeated acts of negligence in her care and treatment of patient K.T. (Factual Findings 8-26.)

Causes of Discipline Regarding the Balance Billing Complaints

4A. Cause of Discipline for Unprofessional Conduct. Cause exists for disciplinary action against Respondent for unprofessional conduct under section 2234, in that it was clearly and convincingly established that she engaged in balance billing in violation of the Knox-Keene Act. (Factual Findings 27-86.)

4B. Health and Safety Code section 1340, part of the Knox-Keene Act, requires health care service plans to cover an enrollee's emergency services, whether provided by a network or non-network provider. Respondent is not affiliated with Health Net, Cigna, Blue Cross or Kaiser, so she is considered a non-network emergency provider for purposes of the five patients in question. A health plan is required to reimburse non-network emergency care providers in an amount that is a reasonable and customary value of the services rendered. Oftentimes, the plan's payment to this provider (Respondent in this case) will be less than the amount billed for by the provider. In that situation there is a balance remaining on the provider's bill. Any attempts by emergency service providers to collect those remaining sums is considered balance billing and is prohibited under *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Ca1.4th 497. The parties agree that the Knox-Keene Act does not prohibit balance billing for non-emergency services. So the crucial issue in this case is whether Respondent provided emergency services.

4C. One of the key disputes in this case is whether the balance billing prohibition applies to Respondent since she is not an emergency room physician per se. The court in *Prospect* did not appear to limit emergency services to only those provided by a staff doctor in an emergency room. The *Prospect* court commented on this when they noted, "for ease of discussion, we will sometimes refer rather loosely to those required to provide emergency services . . . as emergency room doctors, while recognizing that the category is broader than just doctors." *(Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, supra,* 45 Ca1.4th at 501, fn 1.) Moreover, Health and Safety Code section 1317.1,

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[3] All further statutory references are to the Business and Professions Code unless otherwise noted.

subdivision (a)(1), defines "emergency medical services and care" as "medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon." That definition indicates that any physician, or licensed individual operating under the supervision of a physician, may provide emergency medical services. Moreover, the regulation implemented by the DMHC to prohibit balance billing for emergency services specifically applies to "radiologists, pathologists, anesthesiologists, and on-call specialists." (Cal. Code Regs, tit. 28, § 1300.71.39.) Neither the legislative scheme nor *Prospect* offer any support for excluding on-call specialists from the balance billing prohibition. If the health care professional in question is involved in rendering emergency services, whether as an ER physician or on-call specialist such as Respondent, the balance billing prohibition applies.

4D. The issue, then, turns to whether the services in question were "emergency services," since they invoke the balance billing prohibition of *Prospect*. The California Supreme Court in *Prospect* held that the prohibition applies for all emergency services which must be covered by a health plan. The holding in *Prospect* offers some clues. The court summarized the essence of the problem when it observed that, "disputes over emergency medical care must be resolved solely between the emergency room doctors, who are entitled to a reasonable payment for their services, and the HMO, which is obligated to make that payment. A patient who is a member of an HMO may not be injected into the dispute." (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, supra,* 45 Ca1.4th at 502.) As a matter of public policy, the court observed that emergency room doctors and HMOs must resolve their disputes among themselves, because interjecting "patients into the dispute by charging them for the amount in dispute has only an in terrorem effect." (*Id.* at p. 508.) "Billing the patient, and potentially attempting to collect from the patient, will put unjustifiable pressure on the patient, who will often complain to the HMO, which complaints will in turn pressure the HMO to make payment even if it is unreasonable." (*Id.*) Under these circumstances, it appears that the *Prospect* decision should be construed broadly as opposed to narrowly, to avoid the above-described evils and pit-palls of balance billing.

4E. Health and Safety Code section 1371.4, subdivision (b), provides that a health plan "shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee." The word stabilization is not otherwise defined. However, the term "emergency medical condition" is statutorily defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part." (Health & Saf. Code, § 1317.1, subd. (b).)

4F. In the case of J.S. (the adult), Respondent performed surgery in the ER to repair a lip that was cut in half, severing a muscle and artery. For the minor J.S., Respondent repaired a lip that was torn open and bleeding. For S.M, she had facial fractures while she lay sedated and unconscious after a traumatic car accident, then Respondent resuscitated S.M. after her blood

pressure dropped seriously. For patient C.B., Respondent performed an emergency plastic surgery consult and surgery when his finger tip was amputated. When young S.A. was bitten in the face by a dog, Respondent repaired a serious hole in her lip.

4G. Based on the above, Respondent's services in question should be deemed emergency medical services subject to the balance billing prohibition. Each of the five patients presented with serious injury to a body part which, if not treated, could be expected to jeopardize their health and lead to serious dysfunction of the body part. Complainant's emergency medical expert, Dr. Brault, persuasively opined that all five patients fell under the definition of an emergency medical condition. She also persuasively opined that their medical conditions should not be viewed as stabilized until the involved body part, either a hand or face, had been repaired. It was Respondent who performed those procedures. Other facts support this conclusion. Each patient was immediately taken to an emergency room after suffering the injury in question. Respondent characterized these incidents as emergencies on records and bills she generated and sent to the involved HMOs. In fact, in some of the documents, Respondent went out of her way to explain how these qualified as emergencies and, in some instances, that she was the only doctor who could treat the patients. The involved HMOs uniformly accepted Respondent's bills as charges for emergency services and paid some or all of them as such without question. Although Respondent disagreed that the amounts paid by insurance were reasonable, the fact that the HMOs paid her is more evidence that she rendered emergency medical services. As Respondent admitted, HMOs do not pay for cosmetic services.

4H. This conclusion is supported by public policy interests. The *Prospect* court focused on the fact that a patient suffering from an emergency will go to the nearest ER, regardless of whether the ER participates in their HMO or not. So long as the patient has coverage through an HMO, they should not be required to pay for emergency services because the HMO is required by law to reasonably compensate the physician for their services; the physician has recourse to obtain the reasonable compensation through the HMO's internal grievance process and/or civil litigation. The patient, who normally can decide whether to visit a network provider or not in a non-emergency setting, has no control over his/her health care in the emergency context. According to *Prospect*, patients should not be interjected into such a dispute under these circumstances. As between the three parties (the physician, patient and HMO), it is the patient who has the least information, control and power. It is the patient who should therefore be removed from this dispute. Moreover, this is a fair way of dealing with such disputes. None of the five patients in question had any understanding that their insurance would not pay for the services provided, nor did Respondent provide them with any inkling that was a possibility. If Respondent truly provided cosmetic services to the patients, which she knew insurance would not pay, she should have told her patients that. She didn't.

5A. Respondent argues that even if she balance billed in violation of the Knox-Keene Act, she may not be disciplined because the Employee Retirement Income Security Act (ERISA, 29 U.S.C. § 1001 et seq.) preempts the Knox-Keene Act.

5B. Health insurance or health care service plans covering an employee group may constitute an "employee benefit plan" within the meaning of ERISA. Section 514(a) of ERISA preempts all state laws insofar as they "relate to" employee benefit plans covered by Title I of ERISA, subject only to certain exceptions as expressly provided in section 514(b)

of ERISA. "ERISA preempts California's Knox-Keene Act to the extent that Knox-Keene seeks to regulate ERISA-covered employee benefit plans." (*Hewlett Packard Co. v. Barnes* (1978) 571 F2d 502, 505.)

5C. However, the United States Supreme Court discussed the issue of ERISA preemption in the case of *FMC v. Holliday* (1990) 498 U.S. 52. That case clarified two parts of ERISA related to preemption, i.e., the "savings clause," which carves out an exception to the preemption rule, and the "deemer clause." The Court held that if a plan is "self-funded," then ERISA will apply and preempt state law; however, if the plan is a fully insured plan, the savings clause applies, and the plan is subject to state insurance law. "Fully insured" means an employer purchases insurance to pay for its employee benefits (such as health insurance). In contrast, if the employer is "self-insured," the employer does not purchase insurance, but instead pays for benefits (such as employee's medical expenses) out of its own funds. Whether a plan is self-funded or self-insured is important since state regulation of a plan is preempted by ERISA only if the plan is self-insured.

5D. A recent California appellate decision sheds light on this issue. In *Coast Plaza Doctors Hospital v. Blue Cross of California* (2009) 173 Cal.App.4th 1179, the court revisited ER1SA preemption after the *FMC* case was decided, and discussed the interplay of the *FMC* and *Hewlett-Packard* decisions. The patient in *Coast Plaza* worked for an employer who obtained a group healthcare plan, established and maintained by the employer for the purpose of providing medical, surgical and hospital care benefits to its participants (employees). Since the group health plan purchased insurance from the insurer (Blue Cross) to satisfy its obligations, the plan was not considered self-funded. The court relied on the *FMC* case, and found that because the plan did not meet the definition of a self-funded plan, the "savings clause" applied, and ERISA did not preempt enforcement of the Knox-Keene Act. *(Id.* at 1189.) The *Coast Plaza* court easily distinguished the *Hewlett-Packard* case Respondent relies upon. In footnote 1, the court explained that *Hewlett-Packard* only discussed self-funded plans, and that court did not have the benefit of the Supreme Court's much later decision in *FMC*, which clearly laid out the distinction between self-funded and fully insured plans. *(Id.* at 1189.)

5E. Based on the above, ERISA does not preempt the Knox-Keene Act as applied in this case. None of the five patients in question had a self-funded plan that would be subject to preemption. Respondent failed to establish that any of the involved patients had a self-funded plan. As her argument on ERISA preemption is akin to an affirmative defense, Respondent bore the burden of proof, but she failed to meet her burden.

5F. Even if Respondent did not have the burden of proof on this issue, it was clearly and convincingly established in this case that the five patients in question were "fully insured," as opposed to having a self-funded plan. While no evidence was presented suggesting any of the plans were self-funded, the testimony of and documents presented by the insurance company employees, as well as the five patients in question or their parents, all indicate the plans were traditional health care insurance policies.

6A. Respondent also argues that the agreements she had the five patients or their representatives sign were valid and legally enforceable, meaning she could balance bill. It is not clear whether Respondent intends this argument to exonerate her from discipline for having patients sign the agreements, from her practice of balance billing, or both. In any event, Respondent's argument is not well taken and exonerates her from neither.

6B. By operation of the agreement, the involved patients and/or their families would have waived their statutorily protected rights against balance billing for emergency services. Consumers cannot waive such rights if a public interest is at issue. An individual can waive the advantage of a law solely for her benefit, but if a law is established for a public reason, it cannot be contravened by a private agreement. (Civ. Code, § 3513; *Tunkl v. Regents of University of California* (1963) 60 Ca1.2d 92.) A law is generally considered to be established for a public purpose "if it has been enacted for the protection of the public generally, i.e., if its tendency is to promote the welfare of the general public rather than a small percentage of citizens." (*Benane v. International Harvester Co.* (1956) 142 Cal.App.2d Supp. 874, 878.)

6C. In this case, the prohibition against balance billing for emergency services was established for a public purpose and therefore cannot be waived. As discussed above, the *Prospect* court strongly considered the public policy interests in health care funding and the overall harm that would come to members of the public covered by insurance who are subjected to disputes between physicians and their HMOs over emergency service billing. The Knox-Keene Act and its attendant regulations have the same purpose. Thus, Respondent's agreements are unenforceable.

7A. Section 2234 allows the Board to discipline a physician for unprofessional conduct. Although the statute provides that unprofessional conduct includes, but is not limited to, certain enumerated conduct, an overly broad connotation is not warranted. The term unprofessional conduct still must relate to conduct which indicates unfitness to practice medicine, but should not be constricted so as to defeat the legislative purpose. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564.)

7B. In this case, it was clearly and convincingly established that Respondent engaged in unprofessional conduct when she violated the Knox-Keene Act by balance billing five patients for emergency services she rendered to them. Prior to rendering her emergency services and while in the emergency room, Respondent required patients, or their representatives, to sign agreements to accept responsibility for payment of all medical services provided by her in the event their insurance companies did not cover all the costs. As discussed above, those agreements were invalid and contrary to the law. Respondent thereafter attempted to collect the balance of her bills from the five patients. Respondent thereafter compounded the situation when she knowingly violated the Order issued by the DMHC, beginning no later than March 2011, and continuing thereafter through June 2011. Respondent's actions all stemmed directly from her practice of medicine and therefore relate to her fitness to practice. In any event, it was not seriously disputed in this matter that

balance billing for emergency services has been deemed to be an unfair billing practice and that violating such a law directly relates to the practice of medicine. Under these circumstances, Respondent's conduct was unbecoming of a physician and unprofessional.

8. Cause of Discipline for Filing False Documents. Respondent is not subject to disciplinary action under section 2261, in that it was not clearly and convincingly established that Respondent knowingly made and signed insurance claim forms and related documents for four patients which falsely represented the existence or nonexistence of a state of facts related to her practice of medicine. (Factual Findings 73-81.)

9. Cause of Discipline for Dishonest and/or Corrupt Acts. Respondent is not subject to disciplinary action under section 2234, subdivision (e), in that it was not clearly and convincingly established that she committed acts of dishonesty and corruption related to her practice of medicine in the manner in which she presented the insurance claim forms and related documents for the four patients in question. (Factual Findings 73-81.)

Disposition

10A. Section 2229, subdivision (a), provides that "[p]rotection of the public shall be the highest priority" for the Board in exercising disciplinary authority. Though section 2229, subdivision (b), also provides that the Board shall, wherever possible, "take action that is calculated to aid in the rehabilitation of the licensee," subdivision (c) of the same statute also clarifies that "[w]here rehabilitation and protection are inconsistent, protection shall be paramount." Section 2229 is in line with the maxim that license disciplinary proceedings such as this are intended to protect the public but not be punitive against the licensee. (*Medical Board v. Superior Court* (2003) 111 Cal.App.4th 163, 173.)

10B. The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines [11th edition 2011] (Guidelines) sets forth recommended dispositions for disciplinary violations. The recommended minimum discipline for Respondent's violation of section 2234 for unprofessional conduct is five years of probation, coupled with the optional terms of completing an ethics program and having a billing monitor. Suspension is not recommended. The recommended maximum discipline is revocation.

10C. In this case, the misconduct established against Respondent is serious and warrants discipline. DMHC regulations implementing the Knox-Keene Act describe balance billing for emergency services as an unfair billing practice. Yet, none of the other causes for discipline were established against Respondent, i.e., medical malpractice or dishonest/corrupt conduct. As an on-call specialist serving ER patients, Respondent found herself in a gray area of health care law that is not clearly established by the cases, statutes or regulations. Respondent has no other record of discipline by the Board or misconduct. She is an excellent practitioner who obtained good results for her patients and properly responded to their medical needs. Under these circumstances, outright revocation would be punitive and is not warranted.

10D. Some consideration was given to imposing less than the minimum discipline suggested by the Guidelines, given the unique nature of this case and Respondent's prior track record of good conduct and practice. However, there are many aggravating facts which suggest that a lower level of discipline would not adequately protect the public. For example, Respondent caused harm to the five patients in question, who were subjected to emotional and financial turmoil by her aggressive collection efforts which turned out to be illegal. While the legal issue in question is novel and without apparent precedent, Respondent was continually warned by some of her patients (primarily, S.M.'s father), insurance company employees and DMHC staff that she was breaking the law and should stop. Respondent undertook no reasonable efforts to verify if that was the case, such as contacting the Board or obtaining a second opinion from a similarly situated physician or an attorney specializing in the area to confirm or deny those concerns. Even worse, Respondent ignored the Order issued by the DMHC for at least three months. Also of concern is that Respondent gave false testimony during the hearing and that she expressed no remorse, contrition, or indication that there is even a slight possibility that she is wrong. Without appropriate discipline, it is not apparent that Respondent would stop balance billing in inappropriate circumstances. Therefore, the minimum discipline suggested in the Guidelines is warranted, i.e., probation for five years, and the requirement that she complete an ethics program and have a billing monitor. (Factual Findings 1-89.)

10E. More consideration was given to imposing moderate discipline, i.e., more than the minimum discipline suggested by the Guidelines, but less than revocation. However, imposing that level of discipline does not appear useful or warranted. Other than the ethics program and the billing monitor, none of the other optional terms suggested by the Guidelines are justified in this case. Increasing the duration of Respondent's probation does not appear productive, and could be viewed as punitive.

10F. Pursuant to Government Code section 11519, subdivision (d), specified terms of probation may include an order of restitution. In this case, Respondent filed lawsuits against five patients in violation of the Knox-Keene Act. As a condition of probation, Respondent shall dismiss any of those cases still pending. If it has not otherwise been so, Respondent shall request the default judgment against C.B.'s wife be vacated.

ORDER

Physician's and Surgeon's Number G 66298, issued to Respondent Jeannette Yvette Martello, M.D., is revoked pursuant to Legal Conclusions 4 through 7. However, revocation is stayed and Respondent is placed on probation for five years upon the following terms and conditions.

1. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of California Code of Regulations, title 16 (CCR), section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may

deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

2. Monitoring - Billing

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a billing monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's billing shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so

notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of billing, and whether Respondent is billing appropriately. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

3. Restitution

Respondent shall dismiss any of the civil lawsuits she filed against the five patients in question that are still pending. If the judgment Respondent obtained against C.B.'s wife has not yet been vacated, Respondent shall request the court in that case to vacate said judgment. Respondent shall submit to the Board proof that these actions have been completed within 90 days of the effective date of this decision.

4. Notification

Within seven (7) days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent.

Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

6. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. General Probation Requirements

Compliance with Probation Unit- Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes- Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, e-mail address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice- Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal- Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California- Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

12. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: July 12, 2013

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Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JEANNETTE YVETTE MARTELLO, M.D. 701 Fremont Avenue South Pasadena, California 91030 Physician and Surgeon's Certificate G 66298, Respondent.	Case No. 17-2009-197045 OAH No. 2011090556 **THIRD AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Third Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On or about July 11, 1989, the Board issued Physician and Surgeon's Certificate number G 66298 to Jeannette Yvette Martello, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2013, unless renewed. This Third Amended Accusation supersedes the previously filed Amended Accusation.

JURISDICTION

3. This Third Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division[1] deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

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[1] Pursuant to Business and Professions Code section 2002, "Division" shall be deemed to refer to the Medical Board of California.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the certificate holder and the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

7. Respondent is subject to disciplinary action under Business and Professions Code section 2234 in that she engaged in a practice known as "balance billing," in violation of the Knox-Keene Act. The circumstances are as follows:

8. The Department of Managed Health Care (DMHC) is the state agency charged with enforcing the Knox-Keene-Health Care Service Plan. The Knox-Keene Act regulates health care service plans commonly referred to as health maintenance organizations, or HMO's. Health care service plans are required to cover an enrollee's (that is, a patient's) emergency services, regardless of whether they are obtained from a network provider. A health plan is required to reimburse a non-network emergency care provider in an amount that is the reasonable and customary value of the services rendered.

9. Respondent is a plastic surgeon who provides emergency services to health care service plan enrollees in the State of California. She provides services at emergency rooms, including Huntington Memorial Hospital and Providence St. Joseph Medical Center. These hospitals are required to provide emergency services to any person seeking emergency treatment, regardless of that person's ability to pay.

10. In some instances, the health plan's payment to a non-network emergency service provider, such as Respondent, will be less than the amount billed for by the provider. In these cases, there is an outstanding unpaid balance of the provider's billed charges. Respondent has attempted to collect this unpaid balance from the enrollees (patients in our cases). This practice is known as "balance billing" and is illegal.[2] Providers such as Respondent are not allowed to collect this balance from the patient because it violates the Knox-Keene Act. When Respondent could not get money through the enrollees, she filed lawsuits against them.

11. On December 30, 2010, DMHC issued a Cease and Desist Order pursuant to Health and Safety Code section 1391, which ordered her immediately to stop attempting to collect money from health plan enrollees who she saw in the emergency rooms for services rendered. The Order was served on Respondent on February 22, 2011. The Order became final March 24, 2011. Even after being served, Respondent continued to collect or attempt to collect sums for emergency services she provided and claimed, by filing lawsuits against these patients.

Factual Allegations Regarding Patient J.S.:

12. J.S. has been a member of CIGNA since 2008. On November 14, 2009, she had a serious fall and suffered serious injuries including a concussion, fractured nose, as well as other injuries. She was taken to the emergency room at St. Joseph's in Burbank. J.S. met with

[2] On January 8, 2009, the California Supreme Court in a unanimous decision in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* 45 Cal.4th 497 (2009), declared balance billing unlawful in the context of emergency medical care. Where a health plan does not pay, in whole or in part, the amount charged by emergency room doctors, the doctors now must resolve billing disputes solely with the health plans. The providers may seek dispute resolution, or even sue the health plans if they wish, but they may no longer bill patients with a health plan for the disputed amount. In addition, the California Department of Managed Health Care adopted a regulation effective October 15, 2008, defining balance billing in the emergency care context as an unfair billing pattern. (Cal. Code Regs. Tit. 28, section 1300.71.39)

Respondent who told her she needed emergency surgery to stop the bleeding and Respondent did perform surgery.

13. On or about May 21, 2010, Respondent submitted forms to CIGNA for emergency services rendered to this patient. CIGNA paid Respondent $1,400 for the services. In November 2010, CIGNA asked Respondent to cease collection activity against the patient and offered to make her an additional payment. In April 2011, Respondent attempted to return the payments made by CIGNA. On May 9, 2011, Respondent filed a lawsuit against this patient and her sister seeking $10,250.

Factual Allegations Regarding Patient J.S. (a minor):

14. On January 4, 2010, Respondent provided emergency medical services at Huntington Memorial Hospital in Pasadena. J.S., a minor, had suffered significant cuts to his face. Before rendering services, Respondent made his parents sign an agreement to accept full financial responsibility for her medical care, whether or not their insurance paid any portion of the bill.

15. Respondent then submitted a claim to Blue Cross for about $2,400. Blue Cross paid Respondent $615. On March 8, 2010, Respondent sent a letter to the parents demanding $1,040 for the balance of the bill, which they paid. The mother of J.S. called Blue Cross to ask about this bill and they told her that Respondent should not have charged her and they instructed her to call Respondent to get a refund. The mother called Respondent and not only did she refuse to refund her, but she claimed that California law did not apply to her, and the law against balance billing did not apply to her.

16. Subsequently, the parents filed a complaint against Respondent with the California Department of Managed Health Care. Respondent returned the $615 she had received from Blue Cross. In June 2011, Respondent filed a civil complaint against the parents for the full amount of $2,445, well after the Cease and Desist Order became final.

Factual Allegations Regarding Patient C.B.

17. C.B. was a member of Blue Cross since 2004. He is a cabinet maker and on April 27, 2010, he amputated his finger and had to go to the emergency room at Huntington Memorial. He met with Respondent who told him he needed surgery so she admitted him to the hospital and

performed surgery on April 28, 2010. Prior to the surgery, and while in the emergency room, Respondent required C.B. to sign an agreement to accept full financial responsibility for his care whether or not his insurance paid any portion of the bill.

18. On December 30, 2010, Respondent filed a civil complaint against C.B., his wife and their company for breach of contract for about $12,600. Blue Cross had paid Respondent $3,500 for the services rendered, but Respondent returned that check to Blue Cross and then she filed a lawsuit against C.B. for $14,214. Respondent dismissed the suit against the husband and his company, but did not dismiss his wife. On May 4, 2011, Respondent obtained a default judgment against C.B.'s wife for $14,214. On June 3, 2011, Respondent attempted to enforce the default judgment against his wife. On July 22, 2011, Respondent attempted to obtain an order to sell C.B.'s house by filing an Application for Order for Sale of Dwelling.

Factual Allegations Regarding S.A.:

19. In August 2010, S.A., an 11-year-old girl, was bitten by a dog, and was immediately taken to Huntington Memorial Hospital. While waiting in the emergency room, Respondent spoke with the patient's mother and advised that her daughter get immediate surgery. The mother agreed, but before rendering services, Respondent made the mother sign an agreement to accept full financial responsibility whether or not their insurance paid any portion of the bill. On June 3, 2011, after the Cease and Desist order, Respondent filed a lawsuit against the mother for damages in the amount of $9,000.

Factual Allegations Regarding S.M.:

20. S.M., a 20-year-old female, got in a serious car accident on October 31, 2009. She was brought into the emergency room at Huntington Memorial where she stayed until November 3, 2009 and was then transferred to USC University Hospital. She sustained very serious injuries to her face and body. While S.M. was in the hospital in very critical condition, Respondent made her parents sign an agreement to accept full financial responsibility whether or not their insurance paid any portion of the bill.

21. According to her parents, it is unclear whether Respondent provided emergency medical services to their daughter because no plastic surgery was necessary while S.M. was at

Huntington. However, Respondent submitted a bill to Health Net for over $2,000, but they did not pay her the entire amount. Respondent then returned the entire check to Health Net and filed a lawsuit against the parents for approximately $2,500. The lawsuit was dismissed since it violated the Cease and Desist Order, but Respondent has appealed the case.

Allegations of Unprofessional Conduct:

22. Respondent committed unprofessional conduct by ignoring the cease and desist order issued by the Department of Managed Health Care in December 2010;

23. Respondent committed unprofessional conduct when she attempted to collect the balance of the bills from patients J.S. (adult), C.B., S.A., S.M., and J.S. (minor), for emergency medical services rendered. This violates the balance billing provision of the Knox-Keene Act; and,

24. Respondent committed unprofessional conduct when, prior to rendering emergency services and while in the emergency room, she required patients, or their representatives, to sign agreements to accept responsibility for payment of all medical services provided by Respondent in the event their insurance companies did not cover all the costs.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

25. Respondent is subject to disciplinary action under section 2234, subdivision (d) in that she demonstrated a lack of knowledge or skill in discharging professional medical obligations in treating patient K.T. The circumstances are as follows:

A. Patient K.T. had an abdominoplasty performed by Respondent in February 2004 with no apparent complications. In May 2007 she went to see Respondent for a possible breast surgery. K.T. had breast implants placed a year earlier by another plastic surgeon and she wanted to be a "C" cup because she thought her breasts were too large.

B. Respondent was concerned that K.T. may have a bleeding disorder so she referred her for a hematology consult; however, everything was fine.

C. On June 20, 2007, Respondent performed surgery. She removed the implants and replaced them with saline implants. Respondent did a breast lift and removed some breast

tissue. Respondent did not have anything smaller than 400-430 cc, which ended up being too large.

D. Postoperatively, the patient developed marked venous congestion of the left nipple, which means there was no blood flow. This problem was initially treated with medicinal leeches. The patient was taken back to surgery and the left implant was removed on June 22, 2007.

E. On June 26, 2007, K.T. was seen in the ER at Kaiser with a hemoglobin of 6.3 and a hematocrit of 19.7. She had lost a lot of blood as a result of the surgery and the leech treatment. She was admitted to the hospital and transfused with two units of blood.

F. On July 23, 2007, Respondent took the patient back to surgery and removed the right implant since it became exposed.

Allegations of Incompetence

G. Respondent showed a lack of knowledge when she failed to properly plan for this operation and failed to have the appropriate size of implants.

H. Respondent showed a lack of knowledge when she placed too large of implants into the patient's breasts, and it compromised the blood supply to the skin and nipple, resulting in ischemia and partial necroses of the left nipple.

I. Respondent showed a lack of knowledge when she did one surgery to remove the left implant. She should have removed the right implant at the same time and, failure to have done so compromised the right breast.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

26. Respondent is subject to disciplinary action under section 2234, subdivision (c) in that Respondent committed repeated acts of negligence in her care and treatment of patient K.T.

27. The facts and circumstances alleged above in paragraphs 25A through 25F are incorporated herein as if fully set forth.

A. Respondent failed appropriately to monitor the patient's postoperative hemodynamic status, by using the leeches for at least a week, which allowed the patient's blood count to go dangerously low.

FOURTH CAUSE FOR DISCIPLINE

(Filing False Documents)

28. Respondent is subject to disciplinary action under section 2261 in that Respondent knowingly made and signed insurance forms for four patients which falsely represented the existence or nonexistence of a state of facts, related to her practice of medicine. The circumstances are as follows:

29. On or about June 21, 2010, Respondent submitted a 1500 Health Insurance Claim Form with Lakeside entitled "Emergency Plastic Surgery Consultation" for services she provided on November 14, 2009 to J.S. (adult). On this same date Respondent submitted a 1500 Health Insurance Claim Form with Lakeside entitled "Emergency Plastic Surgical Operative Services" for services she provided on November 14, 2009 to J.S. (adult). Respondent also submitted a document entitled "Submitted by Dr. Jeanette Martello, Board Certified Plastic and Reconstructive Surgeon and out-of-network provider" for services rendered to J.S. on November 14, 2009.

30. Although these forms indicate that Respondent performed emergency services, under oath Respondent denied these were emergency services and claims she performed a cosmetic procedure on patient J.S. (adult).

31. On or about January 24, 2010, Respondent submitted the following documents to Anthem Blue Cross for services rendered to patient J.S. (minor) on January 4, 2010: a 1500 Health Insurance Claim Form entitled "Emergency Plastic Surgery Consultation"; a 1500 Health Insurance Claim Form entitled "Emergency Plastic Surgical Procedure"; and a letter addressed to Anthem Blue Cross dated January 24, 2010 explaining the emergency consultation and services she provided to patient J.S. (minor) on January 4, 2010.

32. Although these forms indicate that Respondent performed emergency services, under oath, Respondent denied these were emergency services and claims she performed a cosmetic procedure on patient J.S. (minor).

33. On or about May 19, 2010, Respondent submitted the following documents to Anthem Blue Cross for services rendered to patient C.B. on April 27 and 28, 2010: a 1500 Health Insurance Claim Form entitled "Emergency Hand Surgery Consultation"; a 1500 Health Insurance Claim Form entitled "Emergency Hand Surgical Services"; a correspondence entitled "Emergency Hand Surgery Consultation; and another correspondence entitled "Emergency Hand Surgery Consultation and Operatives Services", explaining the emergency consultation and services she provided to patient C.B. on April 27-28, 2010.

34. Although these forms indicate that Respondent performed emergency services, under oath, Respondent denied these were emergency services and claims she performed a cosmetic procedure on patient C.B.

35. On or about May 17, 2010, Respondent submitted the following documents to Regal Medical Group for services rendered to patient S.M. on October 31-November 3, 2009: two 1500 Health Insurance Claim Forms entitled "Emergency Plastic Surgery Consultation"; a 1500 Health Insurance Claim Form entitled "Emergency Critical Care Time"; a document entitled "Emergency Plastic Surgery Consultation"; a document entitled "Emergency Plastic Surgery Consultation and Other Miscellaneous Emergency Services Including Critical Care Time".

36. Although these forms indicate that Respondent performed emergency services, under oath Respondent denied these were emergency services.

FIFTH CAUSE FOR DISCIPLINE

(Dishonest and Corrupt Acts)

37. Respondent is subject to disciplinary action under section 2234, subdivision (e) in that she committed acts of dishonesty and corruption related to her practice of medicine. The circumstances are as follows:

38. The facts and circumstances alleged above in paragraphs 27-35 are incorporated herein as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate number G 66298, issued to Jeannette Yvette Martello, M.D.; and

2. Revoking, suspending or denying approval of her authority to supervise physician assistants, pursuant to section 3527 of the Code; and

3. If placed on probation, ordering her to pay the Medical Board of California the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: February 21, 2013

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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