WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

DAVID ROSALES, ***Applicant***

vs.

GOLDEN STATE FREIGHTLINES, INC.; REDWOOD FIRE CASUALTY INSURANCE COMPANY, administered by BERKSHIRE HATHAWAY HOMESTATE COMPANIES, ***Defendants***

Adjudication Number: ADJ10428400
Los Angeles District Office

OPINION AND ORDER GRANTING PETITION FOR RECONSIDERATION AND DECISION AFTER RECONSIDERATION

Defendant seeks reconsideration of an April 24, 2024 Findings and Award (F&A) issued by a workers' compensation judge (WCJ) wherein the WCJ found in pertinent part that lien claimant White Memorial Hospital was entitled to reimbursement and penalties and interest.

Defendant contends that it was entitled to a reduction in the charges by lien claimant based upon the existence of an alleged PPO contract and alleged improper coding of lien claimant's bill; that the WCJ improperly allowed separate payments for supply implants and operating room (OR) services; and that lien claimant was not entitled to penalties and interest pursuant to Labor Code section 4603.2(b).

We have not received an Answer from lien claimant. The WCJ prepared a Report and Recommendation on Petition for Reconsideration (Report), recommending that the Petition be denied.

We have considered the Petition and the Report. We have also reviewed the record in this matter. Based upon our review of the record, and for the reasons stated in the WCJ's Report, which we adopt and incorporate, and for the reasons discussed below, we will grant the Petition for

Reconsideration, amend the F&A to clarify that the lien claimant is entitled to an increase and interest pursuant to Labor Code 4603.2(b)(2)[1] and otherwise affirm the F&A.

As the party with the affirmative of the issue, it is defendant who carries the burden of proof. (Lab. Code § 5705, "[t]he burden of proof rests upon the party or lien claimant holding the affirmative of the issue.") Here, defendant relied on an alleged PPO contract to reduce the amounts reimbursed to lien claimant. It is therefore defendant's affirmative burden to establish the existence of a valid and enforceable PPO contract governing its reimbursement arrangement with lien claimant. Defendant claims lien claimant failed to deny existence of the contract, but in an April 13, 2016 letter sent to defendant, which was attached to a document titled "Provider's Second Request for Bill Review," lien claimant stated that the PPO network agreement either "does not exist," or lien claimant was unaware that defendant was "a beneficiary of the alleged PPO network agreement." (Exhibit 2.) Further, notwithstanding lien claimant's letter, whether lien claimant formally denied the existence of the PPO contact is irrelevant in so far as section 5705 is concerned. Defendant still carries the burden of proof. Accordingly, we agree with the WCJ that defendant's affirmative burden of establishing the existence of a valid and applicable PPO agreement was not met herein. (Report, pp. 4-5.)

Defendant contends lien claimant used the incorrect DRG[2] code. According to defendant's bill review expert, the correct code is DRG 563, which "relates to fractures," rather than the code applied, DRG 483, which "relates to major limb attachment." (Petition, p. 5.) The allegation of improper coding, however, was not raised prior to the matter being set for trial, either in the original bill review completed on January 13, 2016, or otherwise. Further, it is unclear how DRG 483 would be more applicable than DRG 563 given that the operative report signed by Dr. John Itamura on September 22, 2015 indicated that the surgery performed on applicant included irrigation, debridement, radial head replacement, and repairs of the lateral collateral ligament and flexor pronator mass. (Exhibit 4, Operative Report of Dr. Itamura, September 22, 2015, p. 1.) We therefore agree with the WCJ that it would appear applicant's surgery was not "more akin to 'Fracture, Sprain, and Dislocation Except Femur, Hip, Pelvis and Thigh w/o MCC' than to 'Major

[1] Unless otherwise stated, all further references to statute are to the Labor Code.

[2] DRG is the acronym for "Diagnosis Related Group," which is a classification scheme for hospital inpatient reimbursement. (See Cal. Code Regs., tit. 8, § 9789.21(i).)

Joint/Limb Reattachment Procedure of Upper Extremities.'" (Report, p. 3.) As such, we find lien claimant's usage of DRG 483 to be appropriate.

Defendant further contends that supply implants and operating room (OR) services do not warrant separate payments under Medicare Claims Processing Manual Chapter 3, Section 10.4, which states, in relevant part, that certain "medical items, supplies, and services furnished to inpatients are covered under Part A." It should be noted, however, that they are still "covered by the prospective payment rate or reimbursed as reasonable costs under Part A." (*Ibid*.) Covered services include laboratory services, pacemakers and other prosthetic devices, radiology services including CT scans, parenteral nutrition service, and transportation including transport by ambulance. (*Ibid*.)

Defendant believes that both, implants and OR services, fall under covered services under the respective categories of "pacemaker and other prosthetic devices" and "laboratory services."

Although an argument can be made as to how implants might fall into the category of "prosthetic devices," it is unclear how operating room services fall into the category of "laboratory services." Indeed, according to Medicare Claims Processing Manual Chapter 16, Section 10, "laboratory services" refers to diagnostic x-ray, laboratory, and other diagnostic tests. Although such services may be conducted in an operating room, it is generally understood that operating room services pertain to preparation and completion of surgeries, as was the case here. As such, we agree with the WCJ that OR service fees should be reimbursed as per the official medical fee schedule (OMFS). (F&A, p. 2.)

Defendant proposed payment according to the formula indicated by their expert bill reviewer, Sue Choi, in her December 14, 2023 declaration, which states, in relevant, part that "acute care hospitals are being reimbursed using the formula DRG weight x 1.2 x hospital specific composite factor." (Exhibit A, Declaration of Su Choi, December 14, 2023, p. 3.) The WCJ in his Report indicated that a "fair reading leads to the conclusion that to the extent the 'prospective payment rate' applies, reimbursement for implants should be made according to it. Absent agreement on the 'reasonable cost,' jurisdiction is reserved to develop the evidentiary record to make that determination." (Report, pp 3-4.) As the WCJ omitted any discussion of OR services in his Report and already provided his decision regarding OR services in his April 24, 2024 F&A, we believe the formula advanced by defendant would only apply to implants. Further, we agree with the WCJ that the formula proposed by defendant may be adopted, with jurisdiction reserved

by the WCJ in the event lien claimant is not in agreement and/or further development of the record is necessary.

Turning to the issue of penalties and interest, section 4603.2(b)(2) provides:

> (2) Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made at reasonable maximum amounts in the official medical fee schedule [OMFS], pursuant to Section 5307.1, in effect on the date of service. Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer. An explanation of review that states an itemization is incomplete shall also state all additional information required to make a decision. A properly documented list of services provided and not paid at the rates then in effect under Section 5307.1 within the 45-day period shall be paid at the rates then in effect and increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization, unless the employer does both of the following:
>
> > (A) Pays the provider at the rates in effect within the 45-day period.
> >
> > (B) Advises, in an explanation of review pursuant to Section 4603.3, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if the physician or provider disagrees. In the case of an itemization that includes services provided by a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the itemization shall satisfy the requirements of this paragraph. An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

The employer is thus required to make payment pursuant to OMFS within 45 days of receipt of each separate itemization of medical services provided, together with any required reports and any written authorization for services, unless the itemization or a portion thereof is contested, denied, or considered incomplete. In such a case, the employer must notify the requesting party through the issuance of an explanation of review (EOR). In addition, when an employer defers utilization review during the time it is disputing liability for a claim, "and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review … shall begin on the date the

determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation 7 after the determination of the employer's liability." (Lab. Code, § 4610(m).) Pursuant to subdivision (i)(2), "[i]n cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of the information that is reasonably necessary to make this determination." (Lab. Code, § 4610(i)(2).) Here, defendant sent an EOR dated January 20, 2016 (Exhibit 3), but failed to substantiate its compliance with either section 4603.2 or section 4610. Further, the EOR was based upon an alleged PPO contract which lien claimant denied in a letter dated April 13, 2016 (Exhibit 2). Accordingly, we discern no error in the WCJ's exercise of jurisdiction to determine the medical necessity of the lien.

Pursuant to section 4603.2(b)(2), the failure to timely pay at the rates then in effect under section 5307.1 subjects the employer to a statutory increase of 15 percent along with statutory interest. While we agree with the WCJ's determination that reimbursement to lien claimant should be increased by 15 percent, we would characterize the additional 15 percent as an increase pursuant to section 4603.2(b)(2), rather than as a penalty.

Accordingly, we grant the Petition for Reconsideration, amend the F&A to clarify that the increase and interest are per section 4603.2(b)(2) in Finding of Fact No. 7 and in section c of the Award and otherwise affirm the F&A.

For the foregoing reasons,

IT IS ORDERED that defendant's Petition for Reconsideration of the April 24, 2024 Findings and Award is **GRANTED**.

IT IS FURTHER ORDERED that the April 24, 2024 Findings and Award is **AFFIRMED**, except that it is **AMENDED** as follows:

FINDINGS OF FACT

7. Statutory increase and interest per Labor Code section 4603.2(b)(2) are to be applied to any balance found due over the amount of credit for sums paid from the date of the service of the invoices to the date of payment.

AWARD

c. Statutory increase and interest pursuant to Finding of Fact No. 7, above.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSÉ H. RAZO, COMMISSIONER

I CONCUR,

/s/ KATHERINE A. ZALEWSKI, CHAIR

/s/ JOSEPH V. CAPURRO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

JULY 18, 2024

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

DAVID ROSALES
ALAN LAW
HEFLEY LAW

RL/*cs*

I certify that I affixed the official seal of the Workers' Compensation Appeals Board to this original decision on this date.
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REPORT AND RECOMMENDATION

ON PETITION FOR RECONSIDERATION

I. INTRODUCTION

Applicant, David Rosales, born [], while employed on 08/14/2015, as a truck driver at Los Angeles, California by Golden State Freightlines, sustained injury arising out of and occurring in the course of employment to his arm, wrist, hand, fingers and right elbow.

The necessity of the hospital treatment furnished by lien claimant White Memorial Hospital from 09/14/2015 through 09/17/2015 was not contested at lien trial. However the value of the services rendered was placed in issue for determination herein.

II. CONTENTIONS

Petitioner defendant contends that billing for 09/14/2015 was incorrectly coded as "DRG483;" that no separate reimbursement is allowed for supply implants and OR services; and that a reduction for a PPO contract not in evidence should be allowed since lien claimant did not deny the existence of a contract.

III. FACTS

Following applicant's admitted injury, he was treated at White Memorial Hospital. The necessity of the medical treatment was not contested at lien trial, the parties having stipulated on 03/08/2024 at lien trial that the goods and services furnished were "reasonably required and necessary medical treatment for this injury."

The sole issues raised were the reasonable value of the services and penalty and interest.

IV. DISCUSSION

DRG coding

According to Defendant's Exhibit B, declaration of Sue Choi, expert witness dated 12/14/2023, "In this particular case, WMMC has received the fee schedule amount of $29,866.00. In 2015 when the services were rendered, WMMC was paid per CCR Section 9789.23 for DRG 483; hospital composite factor 12626.01 x DRG (483) 2.4205 x DWC increase of 120% effective March 5, 2015 warranted $36,673.51." Ms. Choi goes on to state: "However, the actual DRG that should have been submitted by WMMC should have been DRG 563 (Fracture, Sprain Strain and Dislocation Except Femur, Hip, Pelvis and Thigh w/o MCC)"

This after-the-fact objection to the charges is not supported by any explanation of review or other objection. The only EOR proffered or admitted in evidence is Lien Claimant's Exhibit 3, which makes no reference to DRG codes or the nature of the procedure performed.

The declaration goes on to explain that the White Memorial billing (UB-04, which is Lien Claimant's Exhibit 1) includes an ICB-9 code for the injury or condition being treated, but that this code was replaced by ICD-10 as of 10/01/2025, and the ICD-10 "is grouped with DRG 563, not DRG 483. The dates of service are 09/15/2015 through 09/17/2015, which pre-dates the replacement of ICD-9.

Turning to the procedure in question, the surgical report, Lien Claimant's Exhibit 4, John M. Itamura, M.D. of 09/22/2015 describing excising the radial head and placing an implant with two anchors. The declaration does not establish that this is more akin to "Fracture, Sprain and Dislocation Except Femur, Hip, Pelvis and Thigh w/o MCC" than to "Major Joint/ Limb Reattachment Procedure of Upper Extremities."

Separate Payment for Supply Implants and OR Services

The declaration refers to 8 Cal. Code of Reg. Sec. 9789.22 and the Medicare Claims Processing Manual Chapter 3, Section 10.4. This states that "medical items, supplies, and services furnished to inpatients are covered under Part A. Consequently, they are covered by the prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS.

The decision herein provided that "A fair reading leads to the conclusion that to the extent the "prospective payment rate" applies, reimbursement for implants should be made according to it. If not the parties are to determine the "reasonable cost" and reimbursement of that amount is to be made. Absent agreement on the "reasonable cost," jurisdiction is reserved to develop the evidentiary record to make that determination."

If there is a dispute as to how to apply the formula petitioner advances, jurisdiction is reserved.

PPO Contract Reduction

Petitioner urges that it be allowed to take advantage of a PPO contract referenced in Lien Claimant's Exhibit 3, the 01/21/2016 explanation of review.

As pointed out in the Opinion on Decision, no such contract was proffered or admitted in evidence. In fact the reference to the contract includes no identification of it, such as the parties to it, the date or any other terms and conditions of such agreement.

Penalty and Interest

Labor Code Section 4603.2 (b) provides for the imposition of a "statutory increase" (commonly called a "penalty") together with interest on unpaid balances unless within 45 days payment "at the rates in effect within the 45-day period" is made and an explanation of review is issued to the provider. Both are required.

An explanation of review did issue (followed by a second bill review request, Lien Claimant's Exhibit 2, 04/13/2016), however the payment was not "at the rates in effect" based on the evidence presented herein. The statutory increase and penalty attach only to the amount remaining unpaid.

Petitioner reasons that "White Memorial did not deny the existence of the contract and did not place this at issue therefore the Opinion of the Judge that the reduction should be disallowed based solely on the lack of PPO contract and evidence was beyond the issues raised."

The burden of establishing a contract to which a party seeks to bind another rests with the party asserting the contract. The burden was not met by petitioner.

V. RECOMMENDATION

Based on the foregoing the undersigned WCALJ recommends that the petition for reconsideration be denied.

DATED AT OXNARD, CALIFORNIA

DATE: 05/28/2024

WILLIAM M. CARERO
WORKERS' COMPENSATION JUDGE