WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

DAVID TO, ***Applicant***

vs.

GLENTIC, INC.;
THE HARTFORD,
Defendants

Adjudication Number: ADJ14375969
Los Angeles District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

We have considered the allegations of the Petition for Reconsideration and the contents of the report of the workers' compensation administrative law judge (WCJ) with respect thereto. Based on our review of the record, and for the reasons stated in the WCJ's Report, which we adopt and incorporate, we will deny reconsideration.

For the foregoing reasons,

IT IS ORDERED that the Petition for Reconsideration is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE A. ZALEWSKI, CHAIR

I CONCUR,

/s/ JOSEPH V. CAPURRO, COMMISSIONER

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

APRIL 23, 2024

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

ALAN LAW FIRM
LAW OFFICES OF LYDIA NEWCOMB
PROVIDENCE ST. JOSEPH MEDICAL CENTER

LN/pm

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

REPORT AND RECOMMENDATION
ON PETITION FOR RECONSIDERATION

I
INTRODUCTION

Providence St. Joseph Medical Center filed an Application for Adjudication on 3/15/21 alleging that David To, a 46-year-old employee of Glentic Inc., on 3/15/21, sustained injury arising out of and occurring in the course of employment to his hips as a result of a trip and fall. The claim was medical only in nature and accepted by the employer.

Applicant (medical provider) St. Joseph Medical Center has filed a timely, verified, Petition for Reconsideration of the Findings and Order dated 2/5/24 alleging that:

1. By the order, decision or award, the WCAB acted without or in excess of its powers, and;
2. The findings of fact do not support the order, decision, or award.

Petitioner contends that:

1. The Court erred in determining that the applicable Diagnosis Related Group (DRG) in this case is 482, and;
2. The court erred by not awarding penalty and interest.

II
FACTS

David To sustained a work related injury to his left hip on 9/3/20 as a result of an incident where he tripped over some boxes and fell while he was carrying out trash cans (Lien Claimant's 6). A physical exam and medical history were performed by Dr. Chorbajian on the date of injury, and Mr. To was admitted to Petitioner's hospital facility the same day (Lien Claimant's 6). On 9/4/20, Mr. To underwent surgery on his left hip in the form of an open reduction and internal fixation, performed by Dr. Yacoubian (Lien Claimant's 5). Mr. To was discharged from care by Dr.Chorbajian on 9/8/20 (Lien Claimant's exhibit 4). On 9/9/20, prior to the discharge, Mr. To had a consult with Physician's Assistant Oscar Duenas for osteoporosis (Lien Claimant's 7). Mr. Duenas assessed that Mr. To likely had age related osteoporosis.

Petitioner billed the hospital stay using a DRG of 481 and an ICD-10 code of M80852A (Lien Claimant's exhibit 1). Defendant issued an Explanation of Review on 9/24/20 which deferred review until necessity of the medical treatment was determined by Utilization Review (Defense B). On 12/31/20

Defendant issued a new Explanation of Review wherein the DRG was reassigned to 482 based on the operative procedure and review of medical records (Defense A). The review came out to the sum of $23,080.04 which was paid by Defendant to Petitioner (stipulation #3, Minutes of Hearing 12-22-23).

The value of the charges with DRG 481 is $29,287.36 (Defense D).
The value of the charges with DRG 482 is $23,080.03 (Defense C).

The matter was tried on 12/22/23. Petitioner submitted several medical reports that did not include a proof of service (Lien Claimant's 4,5,6,7 & 8). Petitioner also submitted an itemized bill which had no proof of service (Lien Claimant's 1).

The Court issued a Findings and Order dated 2/5/24 wherein it was determined that the appropriate DRG was 482, and that Petitioner was not entitled to penalty and interest. The Court noted in the opinion that there were no actual co-morbidities present (including the secondary diagnosis code of 170 which corresponds to kidney failure) which would qualify Petitioner's charges under DRG 481. Additionally, it was determined that Petitioner was not entitled to penalty and interest because it was not established that the required medical reports were served on Defendant along with the bill as required by Labor Code section 4603.2(b)(2).

III
DISCUSSION

WHETHER THE SERVICES IN QUESTION QUALIFY AS A DRG 481 OR 482

The DRG charts linked to Title VIII CCR section 9789.24 reveal the difference between a DRG 481 and 482. Both DRGs apply to inpatient hospital stays where there is a procedure involving the hip or femur. The procedure in this case was surgery for the hip. Petitioner billed the service using DRG 481. The chart linked to section 9789.24 reflects that there must be a complication or co- morbidity (CC) involved for DRG 481 to apply.

Petitioner argues that the billed ICD-10 code of M80852A established the existence of a co- morbidity (without actually identifying the co-morbidity). But just because the code asserts there is a co-morbidity, doesn't mean it exists in reality. There must be substantial medical proof. The ICD- 10 code in question specifies that the procedure involved "Other osteoporosis with current pathological fracture, left femur, initial encounter for fracture." In looking at the

medical reports issued by physicians in this case, there was no mention of osteoporosis. The history and physical intake from Dr. Chorbajian dated 9/3/20 makes no reference to the condition of osteoporosis. The operative report from Dr. Yacoubian dated 9/4/20, did not identify the presence of osteoporosis. The discharge summary from Dr. Chorbajian dated 9/8/20 includes diagnoses of closed hip fracture, essential hypertension, and benign prostatic hyperplasia, but not osteoporosis. Nowhere in the report is osteoporosis mentioned.

The only medical report which references the condition of osteoporosis is a consult from physician's assistant Omar Duenas dated 9/8/20. Mr. Duenas noted that Applicant had never been treated for osteoporosis and has never had a Dexa Scan to determine bone health. Based on x-rays, Mr. Duenas made the assessment that Applicant likely had age related osteoporosis. Such an assessment is not substantial evidence since it is not a diagnosis from a medical doctor, not based on appropriate imaging studies, and not stated with reasonable medical probability. There is no diagnosis of osteoporosis from any actual licensed medical doctor who treated Applicant for this injury. According to the Medical Treatment Utilization Schedule (MD Guidelines: CA MTUS/ACOEM edition), in order to diagnose osteoporosis, the physician should conduct a Dexa scan or CT scan to determine if the bone density measurements meet the definition of osteoporosis as defined by the World Health Organization. Although a Dexa scan was recommended, it was not performed. As such, the assessment from Mr. Duenas in unsubstantiated speculation. As such, there is no properly documented co-morbidity which would dictate a DRG of 482. Defendant's review using DRG 481 was proper.

PENALTY AND INTEREST

Labor Code section 4603.2(b)(1)(A) provides:

> "A provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service, **a copy of all reports showing the services performed**, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received. This section does not prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600."

Labor Code section 4603.2(b)(2) provides:

> "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, 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."

In the case of *Kunz v Patterson Floor Coverings*, 67 CCC 1588 (2002) (Appeals Board en banc), it was specifically held that "the provisions of section 4603.2 do not apply unless the prerequisites to the section's application have been met, i.e., the medical treatment in question must have been "provided or authorized by the treating physician selected by the employee or designated by the employer [pursuant to section 4600]" and the medical provider's billing to the defendant must have been "properly documented" with an "itemized billing,

together with any required reports and any written authorization for services that may have been received.”””

Here, none of the medical reporting which document the medical treatment services performed have been established to have been served on Defendant. None of the bills or reports include a proof of service. Although it is fairly established that the itemized bill was received by Defendant on 12/24/20, as documented on the Explanation of Review dated 12/31/20, it cannot be inferred that the required medical reports were served along with the itemization. As it is Petitioner’s burden to prove entitlement to penalty and interest, it was found that the burden was not met.

IV
RECOMMENDATION

For the foregoing reasons, the undersigned WCJ recommends that the Petition for Reconsideration be **DENIED**.

Date: March 7, 2024

Jeffrey Morgan
WORKERS' COMPENSATION
ADMINISTRATIVE LAW JUDGE