WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

ROBERT NICHOLS, *Applicant*

vs.

COMCAST;
ACE AMERICAN INSURANCE COMPANY, administered by HELMSMAN MANAGEMENT SERVICES, *Defendants*

Adjudication Number: ADJ13768010

Oakland 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.

Former Labor Code[1] section 5909 provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.) Effective July 2, 2024, section 5909 was amended to state in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.
>
> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

[1] All further statutory references are to the Labor Code, unless otherwise noted.

Under section 5909(a), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected in Events in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on March 7, 2025, 2025 and 60 days from the date of transmission is May 6, 2025. This decision is issued by or on May 6, 2025, so that we have timely acted on the petition as required by section 5909(a).

Section 5909(b)(1) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to act on a petition. Labor Code section 5909(b)(2) provides that service of the Report and Recommendation shall be notice of transmission.

Here, according to the proof of service for the Report and Recommendation by the workers' compensation administrative law judge, the Report was served on March 7, 2025, and the case was transmitted to the Appeals Board on March 7, 2025. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that the parties were provided with the notice of transmission required by section 5909(b)(1) because service of the Report in compliance with section 5909(b)(2) provided them with actual notice as to the commencement of the 60-day period on March 7, 2025.

For the foregoing reasons,

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

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

I CONCUR,

/s/ JOSE H. RAZO, COMMISSIONER

/s/ CRAIG SNELLINGS, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

May 6, 2025

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

JOHN MUIR MEDICAL CENTER
LAW OFFICES OF ALLWEISS, MCMURTRY & MITCHELL
LEWIS, BRISBOIS, BISGAARD & SMITH
GETIXHEALTH

PAG/bp

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

REPORT AND RECOMMENDATION
ON PETITION FOR RECONSIDERATION AND NOTICE OF TRANSMISSION ON MARCH 7, 2025

I
INTRODUCTION

1. Applicant's Age	:	35 years old
Date of Injury	:	9/17/2020
Parts of Body Injured	:	Bilateral lower extremities
Manner in which injuries alleged to have occurred:		Specific incident
2. Identity of Petitioner:		**Lien claimant** filed the Petition.
Timeliness:		The petition was timely filed.
Verification:		A verification is attached to the petition.
3. Date of Order		2/6/2025
4. **Petitioners contentions:** or emergency basis:		The treatment provided for the lien was pre-admission

FACTS

On September 17, 2020, applicant Robert Nichols, was injured during a car accident while working for Comcast. Initially, applicant was sent to Highland hospital where he stayed until September 24, 2020. The medical records contained within the second bill review do not indicate the reason for the movement.

Applicant was admitted to John Muir Hospital on September 24, 2020 to the trauma intensive care unit (Exhibit 1 pg 145). Applicant was discharged on December 3, 2020 from John Muir Hospital.

On March 22, 20201, Defendant sent the explanation of benefits and explanation of review and issued payment according to OMFS. On May 25, 2021, lien claimant timely requested second bill review. Defendant did not send the bills through second bill review.

The matter was set for trial on December 12, 2024. Parties stipulated to a remote hearing which was denied. Defendant filed for removal and the order denying was set aside and the December 12, 2024 hearing was converted to a trial on whether there was good cause to proceed remotely. At the December 12, 2024 hearing the parties limited the issue to whether the treatment was for pre-admission or emergency services. New trial briefs were order to address that limited issue.

On January 30, 2025, the matter went forward with trial and was submitted on the record without any witness testimony to support a claim for pre-admission or emergency treatment. Lien claimant timely filed a petition for reconsideration.

II
DISCUSSION

TREATMENT WAS NOT EMERGENCY SERVICES OR PRE-ADMISSION

Lien claimant's position is that all of the treatment procured at John Muir hospital is emergency or pre-admission and is therefore subject to a different rate. Under CCR 9789.22,

Unless otherwise provided by applicable provisions of this fee schedule, the maximum payment for inpatient medical services shall be determined by multiplying 1.20 by the product of the hospital's composite factor and the applicable DRG weight and by making any adjustments required by this fee schedule. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a hospital for inpatient medical services not exempted under this section. **However, preadmission services rendered by a hospital more than 24 hours before admission are separately reimbursable.** (emphasis added)

According to 42 CFR subsection a 412.2 (c)(5) the definition of preadmission services is:

> Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the **beneficiary's admission to the hospital and during the 3 calendar days immediately preceding the date of the beneficiary's admission to the hospital** that meet the condition specified in paragraph (c)(5)(i) of this section and at least one of the conditions specified in paragraphs (c)(5)(ii) through (c)(5)(iv).

Paragraphs (c)(5)(ii) through (c)(5)(iv) state:

> (ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).(iii) For services furnished on or after October 1, 1991, through June 24, 2010, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following: (A) Ambulance services. (B) Maintenance renal dialysis.(iv) Nondiagnostic services furnished on or after June 25, 2010, other than ambulance services and maintenance renal dialysis services, that are furnished on the date of the beneficiary's inpatient admission or on the first, second, or third calendar day immediately preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such services are unrelated to the beneficiary's inpatient admission.

Here, prior to admission, applicant was at Highland Hospital. Upon the transfer, applicant was immediately admitted as evidenced by the admission report. (Exhibit 1 pg 145). Further, lien

claimant did not provide any evidence or testimony as to what services that comply with the requirements set forth in paragraphs ii through iv for the treatment that was procured on September 24, 2020, the day of admission. Without evidence or testimony, lien claimant fails to prove the treatment was pre-admission.

Next lien claimant argues that Medicare prospective billing does not apply because of emergency services. Citing 42 CFR Sub Part B section 412.20 which states:

> Inpatient hospital services will not be paid under the prospective payment systems specified in § 412.1(a)(1) under any of the following circumstances:….(2) The services are emergency services furnished by a nonparticipating hospital in accordance with § 424.103 of this chapter.

Section 423.103 sets forth the terms in which Medicare will pay for emergency services when the hospital does not take Medicare:

> Medicare pays for emergency services furnished to a beneficiary by a nonparticipating hospital or under arrangements made by such a hospital if the conditions of this section are met. (a) General requirements. (1) The services are of the type that Medicare would pay for if they were furnished by a participating hospital. (2) The hospital has in effect an election to claim payment for all emergency services furnished in a calendar year in accordance with § 424.104. (3) The need for emergency services arose while the beneficiary was not an inpatient in a hospital. (4) **In the case of inpatient hospital services, the services are furnished during a period in which the beneficiary could not be safely discharged or transferred to a participating hospital or other institution.** (5) The determination that the hospital was the most accessible hospital available and equipped to furnish the services is made in accordance with § 424.106. (emphasis added)

Lien claimant argues that the emergent services section should apply in workers' compensation as well; however, the section quoted applies to hospitals that do not participate in Medicare and are therefore out of the prospective payment situation. There has been no evidence submitted nor testimony to support that this provision should apply.

Here, Mr. Nichols was initially hospitalized at Highland Hospital. Upon arriving at Highland Hospital, Mr. Nichols coded and CPR had to be administered. This is clearly an emergent situation.

On September 24, 2020, he transferred to John Muir Hospital "for insurance reasons" (Exhibit 1 pg 147). There is no indication that applicant was in emergent condition and therefore needed to be transferred from Highland Hospital to John Muir. As outlined in 423.103, a patient could not be safely transferred to a participating hospital to be included. Here, applicant was specifically transferred due to insurance issues. The transfer alone excludes John Muir from arguing that applicant was in an emergent condition. Additionally, there is no evidence that John Muir is a nonparticipating hospital which is what triggers 42 CFR Sub Part B section 412.20.

Upon review of lien claimant's petition for reconsideration, there is no change in the undersigned's opinion that lien claimant failed to sustain their burden that applicant was in pre-admission or emergency status the lien period that was claimed.

DEFENDANT'S FAILURE TO PUT BILLS THROUGH SECOND BILL REVIEW

Lien claimant raised defendant's lack of response to the second bill review in the petition for reconsideration. As discussed above, after the December 2024 conversation, the parties limited the issue solely to whether the bills were emergent. Thus, consequences for defendant's failure to put the bills through second bill review was not at issue for the trial. However, neither the labor code or regulations give a specific remedy for failure to respond to a second bill review for medical treatment like it does for med-legal costs in CCR 10786(e).

III
RECOMMENDATION

The undersigned recommends that the petition for reconsideration be denied.

NOTICE OF TRANSMISSION TO THE APPEALS BOARD

On March 7, 2025 this matter was transmitted to the Reconsideration and of the Appeals Board.

DATE: March 7, 2025

Erin Bodner
WORKERS' COMPENSATION
ADMINISTRATIVE LAW JUDGE