

AST

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

Case No. SDO 313688

CRESENCIO BARRERA,

*Applicant,*

vs.

HNR FRAMING; AMERICAN HOME  
ASSURANCE COMPANY, et al.,

*Defendant(s).*

OPINION AND DECISION  
AFTER RECONSIDERATION

GMK

MAY 08 2008

LA

On June 18, 2007, the Workers' Compensation Appeals Board granted reconsideration to further study the factual and legal issues.<sup>1</sup> This is our decision after reconsideration.

In the Findings and Order of March 29, 2007, the workers' compensation administrative law judge (WCJ) allowed, in each of the years 2000 through 2003, a variety of percentages of the total billed liens of Elite Surgery Centers ("Elite"), an outpatient surgery provider with locations in Del Mar, Escondido, and Point Loma, for surgery to various body parts, as more particularly described in a spreadsheet prepared by the WCJ and attached to her decision as Exhibits B-1, B-2, and B-3. These Exhibits are also attached to our decision herein. For the year 2000, for example, the WCJ based the percentage allowed, in some instances, on an "all years' average" for the particular surgery at issue.

The collection of defendants ("petitioners") in these consolidated cases, who are identified in Exhibit A of the Minutes of Hearing of March 12, 2007, sought reconsideration of the WCJ's decision. Petitioners contended, in substance, that the WCJ failed to apply *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 Cal. Comp. Cases 1588 (Appeals Board en banc) to determine the reasonable value of the Current Procedural Terminology (CPT) codes of the American Medical Association at issue in these consolidated case, and that *Kunz* authorizes only reasonable

<sup>1</sup> Former commissioner Janice Jamison Murray concurred in the Order Granting Reconsideration, but she is no longer a member of the Appeals Board, so it was necessary to assign another panel member in her place.

1 ambulatory surgery center fees. Petitioners further contended that the trial testimony of Rocky  
2 Gentner, a witness presented by Elite, is not substantial evidence, that Elite's charges are  
3 unreliable because its billings are inconsistent even when the same procedure utilizing the same  
4 amount of time and resources was performed, that Elite's charges are unreasonable where the  
5 same surgery was performed but different recovery times were involved, that the WCJ's award is  
6 unreasonable because Elite's billings are "consistently inconsistent," that Elite's databases  
7 excluded unfavorable data in order to artificially skew the numbers in its favor, that the WCJ erred  
8 in determining reasonable values for individual CPT codes by combining multiple CPT codes  
9 involving complex surgeries, that the WCJ erred in disregarding Medicare evidence, that the WCJ  
10 erred in disregarding the 2004 Official Medical Fee Schedule (OMFS) based on her assumption  
11 that the workers' compensation medical treatment reimbursement system is a "free market," that  
12 the WCJ erred in failing to consider defense evidence from similarly-situated facilities within the  
13 same geographical area and contracts identifying what other San Diego outpatient surgery centers  
14 accepted for the same services, that the WCJ erred in refusing to consider data compiled by the  
15 California Commission on Health and Safety and Workers' Compensation (CHSWC), that the  
16 WCJ erred in failing to consider amounts accepted by in-patient facilities, that the WCJ erred in  
17 comparing Elite's charges in its closed database to Elite's billings in individual cases within the  
18 consolidation, that the WCJ's award unreasonably allows Elite to recover up to 556% of what in-  
19 patient hospitals accept for the same procedure and up to 930% of what similarly-situated San  
20 Diego surgery centers receive for the same service, that the WCJ failed to discuss defense expert  
21 Stelzner's testimony that reimbursement for a discogram is based on the OMFS, and that this  
22 matter should be reassigned to a WCJ who has expertise in the issues at hand.

23 Elite filed an answer.

24 As noted in the Minutes of Hearing of March 12, 2007, p. 3, the sole issue in these seventy-  
25 five consolidated cases is the reasonableness of the facility charge identified by the corresponding  
26 CPT code in "Exhibit A," which identifies each injured worker and the procedure performed.  
27 Seven general categories of the medical procedure at issue were listed in Exhibit A: Pain

1 management injection, shoulder arthroscopy, knee arthroscopy, back surgery, discography,  
2 "other," and carpal tunnel. On March 12, 2007, petitioners and Elite also stipulated that the WCJ  
3 need only determine "the value of each respective CPT code and the parties thereafter will adjust  
4 the specific liens in each file..."

5 We begin by noting that the WCJ's decision, the specifics of which are set forth in Exhibits  
6 B-1 through B-3, is inconsistent with the parties' trial stipulation requesting a determination of  
7 "the value of each respective CPT code," because the WCJ determined just one "value" per year  
8 for eight CPT codes grouped together as "all epidurals," two CPT codes grouped as "finger  
9 procedures," five CPT codes grouped together as "knee procedures," and three CPT codes for  
10 "shoulder procedures."

11 The legal principles that govern these consolidated cases are set forth in *Kunz, supra*, 67  
12 Cal. Comp. Cases at 1598-1999:

13 "Although facility fees are not subject to the Official Medical Fee  
14 Schedule, any facility fee still must be 'reasonable.' (Lab. Code, § 4600.)  
15 In determining the reasonableness of a facility fee (as with any medical  
16 treatment charge that is not subject to the Official Medical Fee Schedule),  
17 the Board may take into consideration a number of factors, including but  
18 not limited to the medical provider's usual fee, the usual fee of other  
19 medical providers in the geographical area in which the services were  
20 rendered, other aspects of the economics of the medical provider's practice  
21 that are relevant, and any unusual circumstances in the case. (See *Gould v.*  
22 *Workers' Comp. Appeals Bd.* (1992) 4 Cal.App.4th 1059, 1071 [57 Cal.  
23 Comp. Cases 157, 165].)

24 "We emphasize that the 'usual fee' to which we refer is the fee usually  
25 accepted, not the fee usually charged, because that is an aspect of the  
26 economics of a medical provider's practice in the current market. In the  
27 absence of persuasive rebuttal evidence from the defendant, the outpatient  
surgery center's billing, by itself, will normally constitute adequate proof  
that the fee being billed is what the outpatient surgery center usually  
accepts for the services rendered (and that the fee being billed is also  
consistent with what other medical providers in the same geographical  
area accept). The defendant, however, may present evidence that the  
facility fee billed by the outpatient surgery center is greater than the fee the  
outpatient surgery center usually accepts for the same or similar services,  
both in a workers' compensation context and a non-workers' compensation  
context, including contractually negotiated fees. Similarly, the defendant  
may present evidence that the facility fee billed by the outpatient surgery

1 center is greater than the fee usually accepted by other providers in the  
2 same geographical area, including in-patient providers. Although neither  
3 the contractually negotiated amount that an outpatient surgery center  
4 usually accepts nor the amount that in-patient providers usually accept will  
5 necessarily be determinative of what constitutes a 'reasonable' facility fee,  
6 these factors nevertheless will be relevant to what constitutes a  
7 'reasonable' fee (particularly if the fee being billed is grossly  
8 disproportionate either to the contractually negotiated amount that the  
9 outpatient surgery center usually accepts or to the amount that in-patient  
10 providers usually accept for the same or similar services). Of course, if a  
11 defendant offers such rebuttal evidence, the outpatient surgery center is  
12 free to offer contrary evidence, and the Board will resolve the issue of the  
13 lien based on the most persuasive evidence in the record as a whole."

14 In this case, a careful review of the WCJ's Opinion on Decision indicates that she did not  
15 follow *Kunz*.

16 First, we note that there is a contradiction within the WCJ's Opinion on Decision regarding  
17 consideration of Medicare reimbursement rates. On page two of the Opinion, the WCJ stated that  
18 the Medicare standard could not be utilized as a reasonable recovery in this matter, but on page  
19 four the WCJ stated that her determination of the average rate of recovery by Elite from all payors  
20 "included the traditionally low payments by Medicare..."

21 The WCJ also stated that she rejected petitioners' argument that the amounts proscribed in  
22 various contracts between outpatient surgery centers and various insurance carriers should be  
23 considered, because Elite "was not a party to those contracts" and "enjoyed none of the benefits of  
24 the contracts." However, *Kunz* makes no such distinctions.

25 Rather, *Kunz* states that defendant may present evidence that the facility fee billed by the  
26 outpatient surgery center is greater than the fee the outpatient surgery center usually accepts for the  
27 same or similar services, both in a workers' compensation context and a *non-workers'*  
*compensation context, including contractually negotiated fees*, that defendant may present  
evidence that the facility fee billed by the outpatient surgery center is greater than the fee usually  
accepted by other providers in the same geographical area, *including in-patient providers*, and that  
although neither the contractually negotiated amount that an outpatient surgery center usually  
accepts nor the amount that in-patient providers usually accept will necessarily be determinative of

1 what constitutes a 'reasonable' facility fee, *these factors nevertheless will be relevant to what*  
2 *constitutes a 'reasonable' fee.*

3 In this case, the WCJ stated that she considered all of the evidence presented by the parties  
4 to find that the reasonable value of the services provided at Elite's facilities is the average rate of  
5 recovery from all payors, including Medicare. However, there is no indication that the WCJ  
6 considered the fees usually *accepted* by inpatient providers. Rather, it appears that the WCJ  
7 compared only average *billings* for similar procedures performed by inpatient hospitals and Elite,  
8 and found that Elite's billings were not "out of line, being consistently less than the inpatient  
9 billings would be."

10 Furthermore, although the Board emphasized in *Kunz* that on the issue of reasonableness,  
11 the usual fee to which the Board referred is the fee usually accepted, not the fee usually charged,  
12 the WCJ stated in her Opinion on Decision that "the conclusion that the lien claimant accepted an  
13 average of about 67% of the billed amount as payment in full for its services was not the standard  
14 applied" by the WCJ. This seems to be a frank acknowledgement by the WCJ that she did not  
15 follow *Kunz*. Moreover, it is unknown what the WCJ meant when she stated, in the next  
16 sentence, that "the various CPT codes and the percentage of billed for those particular codes for  
17 each of the four years in question appeared to be the fairest assessment in these cases for both the  
18 defendant and the lien claimant."

19 Finally, we note that the WCJ's ultimate findings, i.e., "the percentages allotted for the  
20 specified CPT codes and the years of service," supposedly were based on Elite's Exhibits 10 and  
21 11, which are identified on page five of the March 12, 2007 Minutes of Hearing as "summary of  
22 amounts due Elite Surgical Centers." However, the WCJ's findings are not supported by Exhibit  
23 10, because this exhibit includes no CPT codes. Elite's Exhibit 11 is a list of the "balance due" in  
24 each of the injured worker's cases herein, for each CPT code. However, Exhibit 11 shows that the  
25 amount charged by Elite for each CPT often far exceeded what Elite itself categorized as the  
26 "reasonable and customary" fee. Furthermore, it appears that Exhibit 11 is not categorized by  
27 year, so it is unclear how the WCJ could have used Exhibit 11 to arrive at yearly percentages for

1 each CPT code. Moreover, in reviewing Exhibits B-1 through B-3 of the WCJ's decision, we  
2 note that many of the percentages allowed by the WCJ for the various medical procedures in each  
3 year exceed the 67% percentage that Elite's own witness, Mr. Gentner, identified as a reasonable  
4 average of fees actually accepted by Elite.

5 On the other hand, it is unclear whether the testimony of petitioners' witness, Mr. Stelzner,  
6 established that the facility fees billed by Elite were greater than the fees usually accepted by other  
7 providers in the same geographical area, including in-patient providers. It is also uncertain what  
8 data Mr. Stelzner relied upon for his conclusion that the fees billed by Elite were grossly  
9 disproportionate either to the contractually negotiated amount that Elite usually accepted or to the  
10 amount that in-patient providers usually accepted for the same or similar services.

11 It should be noted, however, that we express no final opinion on the testimony of either  
12 witness, and we express no final opinion on any substantive issue at this time.

13 In summary, the WCJ's decision in this matter is internally inconsistent, and the evidence  
14 she identified does not support her ultimate findings. Most important, the WCJ did not follow  
15 *Kunz*. Therefore, we will rescind the WCJ's decision and return this matter to the trial level for  
16 further proceedings and new decision by a new WCJ. This matter will be referred to the Presiding  
17 WCJ for assignment to a new WCJ, because the WCJ who issued the instant decision is no longer  
18 employed as a WCJ.

19 ///

20 ///

21 ///

22 ///

23 ///

24 ///

25 ///

26 ///

27 ///

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27


For the foregoing reasons,

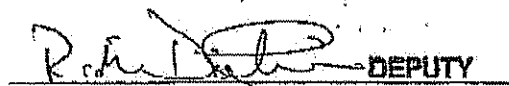
**IT IS ORDERED**, as the Appeals Board Decision After Reconsideration, that the Findings and Order of March 29, 2007 is **RESCINDED**, and this matter is **RETURNED** to the Presiding WCJ for reassignment to a new WCJ, and for further proceedings and new decision by the new WCJ, consistent with this opinion.

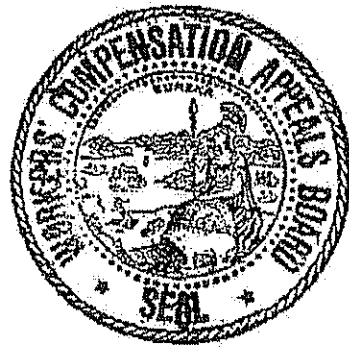
**WORKERS' COMPENSATION APPEALS BOARD**

  
\_\_\_\_\_  
RONNIE G. CAPLANE

**I CONCUR,**

  
\_\_\_\_\_  
FRANK M. BRASS

  
\_\_\_\_\_  
DEPUTY  
RICK DIETRICH



**DATED AND FILED IN SAN FRANCISCO, CALIFORNIA**

**MAY 06 2008**

**SERVICE BY MAIL ON ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES AS SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD:**

**KATTEN MUCHIN ROSENMAN, LLP  
GOLDMAN, MAGDALIN, ET AL  
CMS NETWORK, INC.**

  
\_\_\_\_\_  
JTL/ebc

**BARRERA, Cresencio**