1 WORKERS' COMPENSATION APPEALS BOARD

2 STATE OF CALIFORNIA

3

4 CHARLES HOLDER,

5 *Applicant,*

6 vs.

7 TROY CHRISTIAN dba ADVENTURE
8 LIMOUSINE; THE HARTFORD INSURANCE COMPANY,

9 *Defendants.*

Case No. ADJ1293553 (VNO 046049)

ORDER DENYING PETITION FOR RECONSIDERATION

10

11 Lien claimant David Payne, M.D., Inc. has filed a timely, verified Petition for Removal (Petition)
12 challenging the June 17, 2015, Findings of Fact and Decision in this case. We will treat the Petition as a
13 Petition for Reconsideration.

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

18 / / /

19 / / /

20 / / /

21 / / /

22 / / /

23 / / /

24 / / /

25 / / /

26 / / /

27 / / /

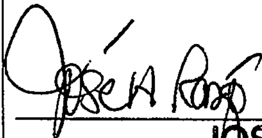
For the foregoing reasons,

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

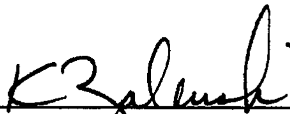
WORKERS' COMPENSATION APPEALS BOARD

DEIDRA E. LOWE

I CONCUR,



JOSÉ H. RAZO



KATHERINE ZALEWSKI

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

AUG 12 2015

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

DAVID PAYNE, M.D., INC. (2)
THE HARTFORD INSURANCE
LEGAL SERVICE BUREAU
LYDIA NEWCOMB

abs

STATE OF CALIFORNIA
Division of Workers' Compensation
Workers' Compensation Appeals Board

CASE NUMBER: ADJ1293553

CHARLES HOLDER	**-vs.-**	**TROY CHRISTIAN dba ADVENTURE LIMOUSINE; THE HARTFORD INSURANCE COMPANY;**
DATE OF INJURY:		**SEPTEMBER 14, 1997**
WORKERS' COMPENSATION ADMINISTRATIVE LAW JUDGE:		**DAVID BROTMAN**

REPORT AND RECOMMENDATION ON PETITION FOR REMOVAL

I.

INTRODUCTION

Applicant Charles Holder, 40 year old chauffer, while employed by Troy Christian doing business as Adventure Limousine on September 14, 1997 sustained injury arising out of and in the course of employment to his back, right shoulder, bilateral lower extremities, bilateral knees and bilateral ankles. The injury occurred when an elevator in which he was a passenger malfunctioned and fell rapidly causing him to hit the floor.

Lien Claimant David Payne, M.D., Inc., by and through his representative of record Legal Services Bureau, has filed a timely, verified Petition for Removal challenging the Findings of Fact and Decision dated June 17, 2015 alleging that:

1. The decision will result in significant prejudice;
2. The decision will result in irreparable harm
3. Reconsideration will not be an adequate remedy after issuance of a final decision or award.

The Findings of Fact and Decision dated June 17, 2015 from which removal is sought found that:

1. Lien Claimant is not entitled to fees above the Official Medical Fee Schedule due to alleged extraordinary circumstances related to the unusual nature of the services rendered for dates of service November 30, 2009 through and including December 31, 2012; and
2. The Court does not have jurisdiction over the issue of Lien Claimant's fees for dates of service on or after January 1, 2013.

II.

FACTS

Lien Claimant David Payne M.D (hereinafter "Petitioner") provided medical treatment to the applicant during the period November 30, 2009 through June 25, 2014. It was stipulated at trial that the medical treatment rendered was reasonable and necessary to cure and relieve from the effects of the industrial injury. Petitioner billed defendant the sum of $159,560.10 and defendant paid the sum of $19,288.86. Petitioner, in addition, adjusted his billing downward in the sum of $39,091.20, leaving a balance claimed due in the sum of $103,180.04.

The matter came before the undersigned Workers' Compensation Judge (WCJ) on April 14, 2015. The issues framed for trial at that time were:

1. Lien of Dr. David Payne; specifically, the reasonable value of services provided with Lien Claimant claiming fees above the Official Medical Fee Schedule based upon extraordinary circumstances; and
2. Penalty and interest per Labor Code Section 4063.2(b).

Testimony was taken and the matter continued for further trial on May 19, 2015.

Both Dr. Payne and the applicant testified to circumstances surrounding his treatment, most particularly in connection with the surgery performed by Dr. Payne in April 2014.

At the parties' request, in order to reach the threshold issues and avoid delay, the issues submitted for decision were amended and were stated as follows:

1. Whether the lien claimant David Payne, M.D. is entitled to fees above the Official Medical Fee Schedule in light of alleged extraordinary circumstances and has he met that burden of proof; and
2. Whether the Court has jurisdiction over the issue of Dr. Payne's fees for dates of service on or after January 1, 2013.

The hearing was concluded and the matter submitted.

III.

DISCUSSION

A. REMOVAL VS. RECONSIDERATION

Petitioner alleges that the Decision "substantially prejudices and harms" Petitioner by not adequately compensating him and by "failing to ensure a reasonable standard of medical care to injured workers", and in leaving "no reasonable remedy" for collection of his bills after 1/1/2013 (Petition, page 2, lines 2-12). Petitioner fails to show how or why reconsideration would not be an adequate remedy after issuance of a final order.

Notwithstanding, it is respectfully submitted that the Decision is in fact a final order with respect to the threshold issues stated as they do determine a substantive right and liability of the parties and that therefore the Petition should more properly be labeled as requesting Reconsideration. A petition for reconsideration may be based on only a final order, decision, or award of the Appeals Board or a WCJ (Labor Code §5903). An order, decision, or award is deemed "final" for purposes of a petition for reconsideration if it determines any substantive right or liability of a party to the proceeding. In order to be final, an order need not resolve all of the issues or represent a final

determination of benefits [*Rymer v. Hagler* (1989) 211 Cal. App. 3d 1171, 1180, 260 Cal. Rptr. 76]. An interim order of the Board or a WCJ that presents a threshold issue is deemed to be final, and may properly be the subject of a petition for reconsideration [*Kosowski v. W.C.A.B.* (1985) 170 Cal. App. 3d 632, 636 n.2, 216 Cal. Rptr. 280, 50 Cal. Comp. Cases 427; *Safeway Stores, Inc. v. W.C.A.B. (Pointer)* (1980) 104 Cal. App. 3d 528, 533, 163 Cal. Rptr. 750, 45 Cal. Comp. Cases 410].

Petitioner himself seems to acknowledge that reconsideration is the proper procedure in arguing that the evidence does not support the finding (Petition, page 4, line 15), a statutory basis for a petition for reconsideration and not removal.

B. FEES ABOVE THE OFFICIAL MEDICAL FEE SCHEDULE

Labor Code §5307.1 as amended in 2004 codified an Official Medical Fee Schedule (hereinafter "OMFS") that established reasonable maximum fees to be paid for medical services. Based upon Labor Code §5307.1, it was found that Petitioner may not recover a fee above the maximum reasonable amount as determined by the Official Medical Fee Schedule.

Title 8 California Code of Regulations §9792(c) arguably allows by its existence a fee in excess of the reasonable maximum fee "if the fee is reasonable, accompanied by an itemization, and justified by an explanation of extraordinary circumstances related to the unusual nature of the services rendered; however, in no event shall a physician charge in excess of his or her usual fee".

Section 9792(c) was last amended in 1999. Former Labor Code §5307.1(b), upon which §9792(c) was promulgated, specifically allowed for such fees in excess of the OMFS. The repealed section of Labor Code § 5307.1(b) stated:

> "Nothing in this section shall prohibit a medical provider or licensed health care facility from being paid by an employer or carrier fees in excess of those set forth on the official medical fee schedule, provided that the fee is:
>
> (1) Reasonable.

(2) Accompanied by itemization and justified by an explanation of extraordinary circumstances related to the unusual nature of the medical services rendered.

In no event shall a physician charge in excess of his or her usual fee."

The language is substantially the same as that found in Rule 9792(c). The statute, however, was repealed as part of Senate Bill 228 in 2003 and, effective January 1, 2004, the new Labor Code § 5307.1 deleted any such language.

Several recent WCAB panel decisions, have raised the issue of the validity of §9792(c) in light of the repeal of its enabling statute. In the case of *Felipe Garcia v. E Recycling of California, Zurich North America*, 2015 Cal. Wrk. Comp. P.D. Lexis 129, the WCAB rescinded a WCJ's finding that a Medical Center was entitled to payment in excess of the inpatient fee schedule set for the in the 2004 OMFS. In that case, lien claimant relied on 8 CCR §9792.1 (c)(2), which exempts inpatient services of specified trauma centers from the maximum reimbursement formula. The Board held that former Labor Code §5307.1 (b), which allowed payment in excess of the OMFS was deleted in 2004 and thus eliminated the enabling statute for Rule 9792.1. In finding that the Lien Claimant was entitled to payment pursuant to the Official Medical Fee Schedule, the Board stated: "Because 2004 OMFS is the fee schedule authorized by Labor Code Section 5307.1, the WCJ should not have relied on Rule 9792.1(c)(2) which addresses an exception to the pre-2004 fee schedule".

In *Jaime Torres Tavera v. T and P Farms, Zenith Insurance Company*, 2015 Cal. Wrk. Comp. P.D. Lexis 117), the WCAB again reversed the WCJ's finding that lien claimant trauma center was exempt from the OMFS and could be paid in excess of the reasonable maximum fee set forth in the fee schedule on the basis that the services were rendered in a life-threatening or urgent setting as stated in Rule 9792.1(c)(2). It was again held that Rule 9792.1 was an exception to the 2003 OMFS and did not apply to the 2004 OMFS.

Petitioner's argument that these cases discussed Rule 9792.1 and not Rule 9792 is a distinction without a difference; the reasoning behind these decisions would hold as applied to Rule 9792 just as they do when applied to Rule 9792.1 as the enabling statute for both was repealed.

The case cited by Petitioner, *Schleifstein v. Leslie's Pool Serve; St. Paul Travelers Insurance*

(2011) (ADJ638016), a panel decision, did not affirm the enforceability of Rule 9792(c) as it found that lien claimant therein had not sustained its burden of proof in any event.

Martinez v. Stifling Brothers, Zenith Insurance Company (2010) 2010 Cal. Wrk. Comp. P.D. Lexis 300, a 1998 injury, dealt with a denied injury, which is not the case here. Petitioner's assertion that some treatment may have been denied is not relevant to the threshold issues presented in this admitted injury case. Petitioner's reliance on *Federal Mogul Corp. v. WCAB* (1973), 38 CCC 584 (writ denied) and *CNA Insurance Companies v. WCAB (Valdez)* (1997) 62 CCC 1145 (writ denied) is likewise inapplicable. Further, a WCAB panel in *Romanita Ayala v. County of Los Angeles/King Drew Medical Center* (2014) 2014 Cal. Wrk. Comp. P.D. Lexis 45 held that the viability of both *Federal Mogul* and *Valdez* was in question given the subsequent adoption of the 2004 OMFS. The WCAB noted as well the repeal of former Labor Code §5307.1 and found that even if it was assumed that Rule 97929(c) was valid, which it questioned, the lien claimant had not sustained its burden of proof.

Bayley v. YMCA of the East Bay (2011) ADJ2367528, seems to have been at least partially decided upon the deleted portion of Labor Code §5307.1 that allowed a fee above OMFS (see Opinion and Order Granting Reconsideration and Decision After Reconsideration dated March 22, 2011, page 7, line 1). The matter was remanded to the trial level and the issue was then settled by stipulation before any subsequent decision.

Petitioner's argument that the decision in this case will deny a reasonable standard of medical care to injured workers also must fail. Labor Code §5307.1(f) states that "*Within the limits provided by this section*, the rates or fees established shall be adequate to ensure a reasonable standard of service and care for injured workers" (italics added).

In the absence of enabling language in the statute, the portion of the administrative regulation upon which it was based is no longer germane and enforceable with respect to the post-1/1/2004 medical treatment charges herein in issue [*Abney v. Aera Energy* (2004) 69 CCC 1552 (en banc); *Mendoza v. Huntington Hospital* (2010), 75 CCC 1204 (en banc)]. An administrative regulation may not exceed the scope of its enabling statute (Government Code §11342.2). Further, the legislature

has made it clear in passing the new Labor Code §5307.1 that the new 2004 fee schedule was intended to be a *maximum* fee schedule.

The undersigned did not ignore the testimony in this case. In light of the finding on the threshold issue, however, it was not germane. The issues of whether or not Dr. Payne carried his burden of proof as to whether the circumstances were "extraordinary" and related to the unusual nature of the services rendered; that his charges were "reasonable"; that his charges were "not in excess of his usual fee"; and/or that his charges were "accompanied by an itemization, and justified by an explanation of extraordinary circumstances related to the unusual nature of the services rendered" were all rendered moot.

Based thereon, it was found that lien claimant is entitled to a reasonable maximum fee pursuant to and limited by the Official Medical Fee Schedule for his charges commencing 11/30/2009 through and including 12/31/2012, in an amount to be adjusted by and between the parties with the WCAB retaining jurisdiction in the event of a dispute.

C. JURISDICTION OVER TREATMENT SERVICES POST 1/1/2013

Pursuant to Labor Code §§4603.2 and 4603.3, effective January 1, 2013, disputes over fees for medical services provided on or after January 1, 2013 are to be resolved through the Independent Bill Review procedure (see also Tile 8 California Code of Regulations §§9792.5.1 through 9792.15). The role of the WCAB is limited to ruling on appeals from medical bill review determinations of the Administrative Director (Labor Code §4603.6)

The case herein involves medical treatment provided by Dr. Payne during the period commencing 11/30/2009 through 6/25/2014 (Minutes of Hearing, April 14, 2015 at page 2). With respect to those charges for dates of service 1/1/2013 through 6/25/2014, the Court lacks jurisdiction to determine the reasonable fee. As to those charges for the period 11/30/2009 through 12/31/2012, the Court retained jurisdiction over the billing dispute.

Petitioner's reliance on *California Insurance Guarantee Association v. Workers' Comp.*

Appeals Bd. (2014) 232 Cal. App. 4th 543, 181 Cal. Rptr. 3d 449, 79 Cal. Comp. Cases 148 is misplaced. The charges in that case all predated 1/1/2013. The Court specifically declined to address whether the IBR process was to apply to dates of injury 1/1/2013 and after or dates of treatment 1/1/2013 and after (see Footnote 16 at 232 Cal. App. 4th 567: " We need not determine whether the triggering event for purposes of application of the new IBR process to a dispute is whether the relevant employment-related injury occurred on or after January 1, 2013, or, rather, whether the service provided to an employee for which the bill is in dispute occurred on or after January 1, 2013, since the injuries and services at issue in this case all occurred many years prior to January 1, 2013"). Contrary to Petitioner's assertion, the case herein does not present a dispute that was "pending" at the time of enactment since all the charges in *CIGA* were incurred prior to 1/1/2013. Rather, as the charges herein span a period of time both before and after 1/1/2013, the issue was framed and the Decision was made applicable only to those dates of service after 1/1/2013.

The Court in *CIGA* did, however, confirm that SB 863, effective January 1, 2013, created an independent bill review process by which billing disputes between providers and employers are to be resolved administratively, not by the WCAB (other than disputes were pending on 1/1/2013).

It is abundantly clear, however, that the procedures for Independent Bill Review were intended to be applicable to dates of service 1/1/2013 and after. Title 8 California Code of regulations 9792.5.4, "Second Review and Independent Bill Review – Definitions" states:

> "This section is applicable to medical treatment services and goods rendered under Labor Code section 4600, or medical-legal expenses incurred under Labor Code section 4620, on or after January 1, 2013."

Rule 9792.5.7 also refers to application of the procedure to medical treatment services rendered on or after January 1, 2013.

In Aziza Sayed v. Giorgio Armani, Federal Insurance Company (2014) 2014 Cal. Wrk. Comp. P.D. Lexis 543, the Board panel applied the IBR process to a date of injury 8/9/2005 for services after 1/1/2013. The treating physician had placed in issue charges for services beginning in 2012 through 2014.

8 CCR 9792.5.5 states: "(a) If the provider disputes the amount of payment made by the

claims administrator on a bill for medical treatment services or goods rendered on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses incurred on or after January 1, 2013, submitted pursuant to Labor Code section 4622, the provider may request the claims administrator to conduct a second review of the bill".

The record herein contains numerous Explanations of Review issued by defendant (i.e., Lien Claimant Exhibits 5, 6, 8, 9, 10, 16, 25, 26, 39, 43, 44, 49, 50, 69, 76) after 1/1/2013. There is no written evidence that Lien Claimant disputed the payments and/or initiated any request for IBR. Defendant's payment log, Exhibit A, documents numerous payments to Dr. Payne made for dates of service 1/1/2013 and later.

Petitioner indeed had a remedy through the IBR process if he disputed the payments made by defendant for services rendered after 1/1/2013; there is no evidence that he availed himself of that remedy.

It is further noted that if the legislature had intended that there be an exception for fees over the OMFS for dates of service 1/1/2013 and later, that some procedure for same would have been reflected in the IBR procedure.

IV

RECOMMENDATION

It is recommended that the Petition for Removal be dismissed and the Petition for Reconsideration be denied.

Respectfully submitted,

Dated: July 17, 2015

DAVID BROTMAN
Workers' Compensation Administrative Law Judge

LEGAL SERVICE BUREAU
888 W. Santa Ana Blvd. Suite 100
Santa Ana, CA 92701
Tel: (714) 210-3500
Fax: (714) 210-3505
REPRESENTATIVE FOR LIEN CLAIMANT DAVID PAYNE, M.D., INC.

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

CHARLES HOLDER,

Applicant,

vs.

SHOWTIME LIMOUSINE; THE HARTFORD.,

Defendants,

DAVID PAYNE, M.D., INC.,

Lien Claimant

Case No. ADJ1293553

PETITION FOR REMOVAL

Comes now, Lien Claimant DAVID PAYNE, M.D., INC, and through his representative of record, LEGAL SERVICE BUREAU, and seeks removal of the Findings of Fact issued on June 17, 2015. These Findings of Fact were issued after a hearing on Dr. Payne's lien for dates of service November 30, 2009 through and including June 25, 2014.

At trial, the WCJ deferred the issues of the reasonable value of the fees for medical treatment, as well as the penalty and interest thereon, and determined only the following two (2) issues:

1. Whether Lien Claimant, David Payne, M.D., is entitled to fees above the OMFS in light of alleged extraordinary circumstances and has he met that burden of proof.

2. Whether the Court has jurisdiction over the issue of Dr. Payne's fees for dates of service on or after January 1, 2013.

PETITION FOR REMOVAL

Petitioner aggrieved by the June 17, 2015 Findings and Award of the WCJ, hereby petitions for removal upon the following grounds:

1. The order decision or action will result in significant prejudice;
2. The order, decision or action will result in irreparable harm;
3. Reconsideration will not be an adequate remedy after issuance of a final order decision or award.

In support of this petition, Lien Claimant DAVID PAYNE, M.D., provides the following statement of facts and a discussion of the law applicable thereto.

STATEMENT OF FACTS

This matter involves treatment, including spinal hardware revision surgery, which occurred during the period of November 30, 2009 through June 25, 2014.

The first lien claim filed in this case, on May 18, 2012 (EAMS Doc ID 14283638).

As stipulated by the parties, this period of treatment involved a total billing of $159,560.10. Defendant paid a total of $19,288.86. Lien Claimant gratuitously adjusted $37,091.20 from its bill and has claimed the balance of $103,180.04 by his final lien dated February 24, 2015, properly filed in EAMS (Doc. ID 0011547004) with the $150.00 filing fee paid. (Transaction ID K7Z8C68LWMPC5.)

At the close of the first day of trial (May 19, 2015), the WCJ requested points and authorities on whether the Board has jurisdiction given the IBR procedures which were recently enacted as part of SB 863. This brief was filed on

April 15, 2015 (EAMS Doc ID. 14532627).[1] The matter was then submitted immediately after the second day of trial, May 19, 2015.

The WCJ issued a Findings and Award dated June 17, 2015 (EAMS Doc. ID 56785869) finding that:

1. Lien Claimant David Payne, M.D. is not entitled to fees above the Official Medical Fee Schedule due to alleged extraordinary circumstances related to the unusual nature of the services rendered for dates of service November 30, 2009 through and including December 31,2012.

2. The Court does not have jurisdiction over the issue of Lien Claimant David Payne M.D.'s fees for dates of service on or after January 1, 2013.

It is from these findings, which do not constitute a final order subject to reconsideration, that Petitioner seeks removal.

I.

THIS PETITION FOR REMOVAL IS PROPER

A. Authority.

Petitioner is requesting that this case be removed to the WCAB and that the Board rescind the WCJ's June 17, 2015 Findings and Award.

Labor Code § 5310 provides that the Appeals Board has jurisdiction to "remove to itself" the proceedings on any claim.

The June 17, 2015 Findings and Award is an "order or decision or... action" within the meaning of 8 Cal. Code Regs. § 10843(a) and thus subject to review by the Board on removal.

B. Substantial Prejudice and Irreparable Harm.

A petition for removal must demonstrate "significant prejudice" and/or "irreparable harm" and that reconsideration will not be an adequate remedy after the issuance of a final order, decision, or award. 8 Cal. Code Regs. § 10843(b).

---

[1] The arguments made in the points and authorities filed by Lien Claimant on April 15, 2015 are reiterated, verbatim, in Section V. of this petition for removal.

Petitioner contends that the action of the WCJ, which limits Petitioner's recovery to the OMFS, substantially prejudices and harms petition who provided medical treatment services which can fairly be described as extraordinary and which, if paid at the OMFS, will not adequately compensate the provider.

Further, by the WCJ's decision interpreting Rule 9792(c) as repealed, extinguishing the right of a medical provider to be paid a fee above the OMFS where extraordinary circumstances have been proven, the Board will fail to ensure a reasonable standard of medical care for injured workers.

Petitioner also contends that by finding no jurisdiction over the post-1/1/13 charges, the Board has left Petitioner with no reasonable remedy for collection of its bills for this period of time, denying it due process and adjudication of its claim for reimbursement of medical treatment furnished after 1/1/13.

II.

THE EVIDENCE DOES NOT SUPPORT THE WCJ'S FINDING DENYING PETITIONER FEES ABOVE THE OMFS

If a physician contends that a fee in excess of the OMFS is justified, he or she carries the burden of proof on that issue and has the burden of proving that the amount claimed is a reasonable fee. Some recent panel decisions have described a lien claimant, who seeks fees above the OMFS, as bearing the burden of proving that the fee allowed by the OMFS is insufficient.

Lien Claimant contends that the evidentiary record in this matter contains a multitude of facts which support Lien Claimant's claim that the services provided justify payment above the OMFS.

Title 8, Code of Regulations, § 9792 subsection (c) provides as follows:

> A medical provider or a licensed health care facility may be paid a fee in excess of the reasonable maximum fees if the fee is reasonable, accompanied by itemization, and justified by an explanation of extraordinary circumstances related to the unusual nature of the services rendered; however, in no event shall a physician charge in excess of his or her usual fee. Title 8 Code of Regulations § 9792(c).

Under the "plain meaning" rule, words used in a statute should be given the meaning they bear in ordinary use. (Lungren v. Deukmejian (1988) 45 Cal.3d 727, 735.) Black's Law Dictionary defines "extraordinary" as:

> "[o]ut of the ordinary; exceeding the usual, average, or normal measure or degree; beyond or out of the common order, method or rule; not usual, regular, or of a customary kind; remarkable; uncommon; rare; employed for an exceptional purpose or on a special occasion." (Black's Law Dict (6th ed. 1990).)

The evidence in this case, including the medical evidence received at trial, demonstrates that this is not an ordinary or average case when it comes to the circumstances surrounding the medical treatment furnished by Dr. Payne. These facts demonstrate "extraordinary circumstances" and show services of an "unusual nature." Taken in aggregate, these extraordinary circumstances justify fees above the OMFS.

1. Defendant did not Engage in Payment Actions to Dr. Payne Which were Consistent with an Admitted-Injury Case, Placing Dr. Payne in a Position of Continuing Treatment with No Assurance of Proper Payment.

The Board has recognized that under some circumstances the OMFS may not establish the maximum fee due for treatment self-procured by an applicant when the defendant denies all liability for medical treatment on the grounds that the injury did not arise out of and/or was not incurred in the course of employment. (See Federal Mogul Corp v. Workmen's Comp. Appeals Bd. (Whitworth) (1973) 38 Cal.Comp.Cases 584 (writ den.); CNA Insurance Companies v. Workers' Comp. Appeals Bd. (Valdez) (1997) 62 Cal.Comp.Cases 1145 (writ den.).) While Federal Mogul may not still be good law, the Board has, in other panel decisions, suggested that a Defendant's denial of the injury, AOE/COE is one of the factors which may be used to demonstrate that the case involves extraordinary circumstances.

///

Not all of applicant's treatment plan was approved. According to Dr. Payne's testimony at trial, "The applicant returned to his care in November 2009 as his condition had deteriorated. Medication, physical therapy, and limited pain management was approved by the carrier but some of his treatment plan was denied."[2] Hartford denied authorization for the surgery performed by Dr. Payne.[3]

Because Defendant denied much of the treatment, including the surgery, Dr. Payne was required to take a risk that he would not be paid at all. The Fact that Dr. Payne continued to provide professional and compassionate care to an injured worker with no assurance that he would ever be paid a fair value for his services, is a factor which is proper to consider when determining whether fees above the OMFS are properly awarded to Dr. Payne.

The Valdez case, *supra*, cites the public policy rational of encouraging medical provides to participate in the workers' compensation system by providing medical treatment in denied injury case and to where a doctor provides treatment in case for which he is not being paid, the OMFS does not apply. The same rationale should apply if the doctor is being paid only a small part of what is properly due since there is no assurance that he will not suffer a monetary loss by treating the patient when the sums paid do not even cover his operating expenses.

As fully explained in Valdez, good public policy requires that in a case where the employer refuses to properly pay or provide medical treatment, reimbursement of reasonable, usual and customary charges without regard to the OMFS is justified to ensure continued access to medical treatment without a potential burden on public resources.

2. Besides Taking a Risk of Non-Payment, Dr. Payne is Also Entitled to Fees Above the OMFS Based upon the Extraordinary Circumstances Presented by his Complex and Unusual Nature of the Treatment in this Case.

---

[2] April 14, 2015 Minutes of Hearing and Summary of Evidence, 15:16-18.

[3] See April 14, 2015 Minutes of Hearing and Summary of Evidence, 16:16-17.

In reaching the finding that Petitioner is not entitled to fees above the OMFS, the WCJ appears to ignore the facts of this case, relying only on recent panel decisions, discussed in Section III., herein.

Petitioner's 102 exhibits were augmented by Dr. Payne's testimony at trial. The WCJ's Summary of Evidence during the direct examination of Dr. Payne documents the evidence of extraordinary circumstances.

> The applicant had multiple medical problems including asthma, congestive heart failure, coronary artery disease, poor left ventricular ejection fraction, which was 65% of normal, and he weighed 380 pounds. Because of his obesity, he had become sedentary, which contributed to a worsening of his diabetes, type 2, and hypertension. He suffered from sleep apnea and motor and sensory deficit in both legs with numbness. He was unable to stand for more than fifteen minutes. He suffered from Pickwickian syndrome and would stop breathing during sleep. He had coronary artery spasms and low testosterone due to his obesity.
>
> When the applicant called him from Cedars, he was incredulous at his rapid deterioration. The witness was afraid for the applicant and could sense that the applicant was very fearful of both having the surgery or not having it. The applicant did not know what to do. He had known the applicant for ten years and could tell he was mentally upset, and he thought the applicant thought that he would rather die. The applicant suffered from chronic severe pain, had stepped up the quantity and quality of his pain medications, which at the time included Dilaudin and Percocet. In his experience, patients with such pain may become suicidal, and that was one of the reasons he felt it necessary to fly back to California from North Carolina. He told the applicant that he would return to California but that he could not perform surgery at Cedars as he did not have privileges there. He told the applicant to go to another facility at West Anaheim Hospital. He was treating this as an emergency and canceled his schedule. He requested authorization for the surgery from the carrier. The original doctors at West Anaheim declined to do the surgery as they felt it was too dangerous and life-threatening. Hartford denied authorization to the surgery. The applicant lost hope and was expressing suicidal ideation. Based on the denial by Hartford, he accepted the risk of nonpayment for his services. He performed the surgery on April 30,

2014 and incurred additional costs, including having to procure the films, review the studies, prepare the applicant for surgery, and explain the issues of surgery to the applicant. There were additional facility costs for several meetings with the applicant.

The surgery of April 30, 2014 was a major operation that lasted eleven hours. There was a significant chance that the applicant would not survive the surgery. He performed a revision of the prior four screws that had been placed in the spine. Bone had grown over the screws and they were not visible. The screws that had been used were no longer manufactured. He had to use a drill to burr out the screws. He then had to remove the screw head but none of the universal sets fit those old screws. He was able to remove three of the screws but the fourth one broke the instrument. He therefore had to burr through the rod as well, being very careful. He then used a special tool to take out the last screw. The applicant's facets had grown over and were covered in fat. This caused additional extraordinary effort on his part. Blood had pooled in the spinal canal, leading to scar tissue and a durotomy had to be repaired. Due to the applicant's weight, the table broke two times during the surgery. He had never operated on a 380-pound patient before. Most other surgeons would have referred him out. Ron Fillmore was the assistant surgeon for this procedure.

The applicant was initially injured when he was in an elevator that broke and fell two stories and struck the floor. He was taken by ambulance to the hospital.

Prior to the surgery, the applicant had become addicted to narcotics and had become a recluse and was deteriorating. Three days after the April 2014 surgery he had to perform a second procedure to repair the dura and put in a catheter to drain spinal fluid.

After November 2009, the applicant would call him on numerous occasions as he was continuing to deteriorate; for example, his bill dated 6/29/2010 with code 99372. The applicant had his cell number. He estimates over a hundred calls over a four and a half year period, although he did not bill for all of them.

He has done thousands of spinal surgeries. The applicant is in the top 1% of 1% of difficulty of all he's done.

There was post-operative follow-up, he was authorized six monthly post-op visits. The applicant did extremely well. Thirty days post-op, he was off all medicines except Aleve, was fully ambulatory and his

> demeanor was back to his old self. He lost some weight and weighed 320 pounds. All of his medical problems had improved and he looked like an athlete.
>
> At the time of his last date of service on 6/25/14, the applicant had no residual complaints. He achieved an excellent result and was completely cured of injury.
>
> His billings are within his usual and customary charges. He did not increase any charges in the bill. April 14, 2015 Minutes of Hearing and Summary of Evidence, 16:1 through 17:24

Throughout the entire course of treatment, Dr. Payne struggled with the challenges posed by this large individual whose weight has fluctuated between 320 and 380 pounds. He struggled with applicant's narcotics addiction, his suicidal ideation and a very, very difficult surgery which involved many unusual complications.

The treatment furnished and circumstances relating to the complex services provided by Dr. Payne, taken as a whole, demonstrate extraordinary circumstances related to the unusual nature of the services rendered and justify fees above the OMFS.

III.
WHETHER TITLE 8, CCR SECTION 9792(c) ALLOWING FOR FEES ABOVE THE OMFS UPON A SHOWING OF EXTRAORDINARY CIRCUMSTANCES, WAS REPEALED BY SB 228, THEREBY LIMITING LIEN CLAIMANT TO THE OMFS

According to the WCJ's Opinion on Decision, he relies on WCAB panel decisions which "have raised the issue of the validity of §9792(c)" citing two panel decisions: *Felipe Garcia v. E. Recycling of California, Zurich North America*, 2015 Cal.Wrk.Comp.P.D. Lexis 129 and *Jamie Torres Tavera v. T and P Farms, Zenith Insurance Company*, 2015 Cal.Wrk.Comp. P.D. Lexis 117.

///

///

///

1. Neither the Garcia case nor the Tavera panel decisions involve a determination of Rule 9792(c), allowing fees above the OMFS based on extraordinary circumstances.

The panel decisions in Tavera and Garcia each turn on the Board's analysis of 8 CCR 9792.1(c)(2), which relates only to "Inpatient services provided by a Level I or Level II trauma center...to a patient with an immediately life threatening or urgent injury." While the applicant in this case arguably had a life-threatening condition brought on by his narcotics addition and suicidal ideations secondary to his chronic pain, Petitioner has brought its claim for fees above the OMFS under 8 CCR 9792(c), a regulation which is not addressed in Tavera or Garcia.

2. The Board's Analysis of Rule 9792(c) as set forth in the March 22, 2011 panel decision in the matter of Roger Schleifstein v. Leslie's Pool Supply; St. Paul's Travelers Insurance, ADJ638016, correctly finds that Rule 9792(c) remains in force.

Petitioner is, concurrent with this petition, requesting judicial notice of the Opinion on Decision after Reconsideration in Roger Schleifstein v. Leslie's Pool Supply; St. Paul's Travelers Insurance, ADJ638016 (March 22, 2011), which is being EAMS filed separate from this petition.

In the Schleifstein case, a Board panel of Commissioners Moresi, Cuneo and Miller, find (beginning at page 4, lines 25), that

> The OMFS and accompanying regulations (Cal.Code.Regs., tit. 8 §9790 et seq.) were promulgated by the Administrative Director (AD) pursuant to the authority granted by the Legislature in Labor Code sections 133, 4603.5, 5307.1(l) and 5307.3. As described in the regulations, the OMFS establishes a "reasonable maximum fee" for the services provided by a treating physician. (Cal. Code Regs. Tit. 8, § 9792(c).) In that regard, Rule 9792(c) further provides in pertinent part as follows:

///

> "A medical provider or a licensed health care facility may be paid a fee in excess of the reasonable maximum fees if the fee is reasonable, accompanied by itemization, and justified by an explanation of extraordinary circumstances related to the unusual nature of the services rendered; however, in no event shall a physician charge in excess of his or her usual fee."

As can be seen, a physician may seek a fee that exceeds the reasonable maximum established by the OMFS only when he or she proves that the amount of the fee claimed is reasonable, that the higher fee is justified by extraordinary circumstances related to the unusual nature of the services rendered, and that the amount claimed is not in excess of the physician's usual fee. These requirements are consistent with the holding of the Appeals Board that a lien claimant carries the burden of proving that the amount claimed is reasonable. [cites omitted.]

Thus, the Board regulation, 9792(c), permitting fees above the fee schedule based on extraordinary circumstances, **is actually the Administrative Director's valid and enforceable interpretation of the statutory term "maximum reasonable fee" which, absent extraordinary circumstances, is established by the OMFS**.

Simply stated, it is Petitioner's position that the presumed maximum reasonable fee established by the OMFS may be exceeded, under Rule 9792(c), by evidence that a higher fee is fair and justified.

3. Other Board panel decisions support a finding that fees above the OMFS are properly awarded where a showing of extraordinary circumstances is made.

In Martinez v. Sifling Brothers, Zenith Insurance Company, 2010 Cal. Wrk. Comp. P.D. LEXIS 300, (panel opinion filed July 19, 2010), the Board replied to the petitioner's assertion that because the injury was denied, fees above the OMFS

///

are properly awarded. The Board panel of Commissioners Lowe, Sullivan and Cuneo, stated:

> But even if defendant did not initially accept liability for the injury or approve the treatment, lien claimant's assertion misses the point that under Rule 9792(c) the OMFS establishes a "reasonable maximum" fee for services that are provided unless the lien claimant proves that the OMFS fee is not reasonable because of "extraordinary circumstances related to the unusual nature of the services rendered." A defendant's denial of liability on the grounds that there is not an industrial injury or delay in approving treatment does not in and of itself demonstrate that there are "extraordinary circumstances" related to the provision of services of an "unusual nature" as required by Rule 9792(c).

Next, in Bayley v. YMCA of the East Bay, WCAB Case No. ADJ 2367528 (panel opinion filed March 22, 2011) the Board found that payment of the amount allowed by the OMFS may not fully satisfy an employer's duty to provide reasonable medical treatment under Labor Code § 4600. The Board panel of Commissioners Lowe, Moresi and Brass reasoned as follows:

> A defendant is obligated to provide an injured worker reasonable medical treatment, and a lien claimant is entitled to recover a reasonable fee for services it provides to cure or relieve the worker from the effects of an industrial injury. (Lab. Code, § 4600; Kunz v. Patterson Floor Coverings, Inc. (2002) 67 Cal.Comp.Cases 1588 (Appeals Board *en banc*) (Kunz); Tapia v. Skill Masters Staffing (2008) 73 Cal.Comp.Cases 1338 (Appeals Board *en banc*) (Tapia); c.f. Guitron v. Santa Fe Extruders (March 17, 2011, No. ADJ163338 /LAO 0873468) 76 Cal.Comp.Cases (Appeals Board *en banc.*) (Guitron).)[Footnote omitted.]

Based on the findings of the Board as shown in panel decisions which actually analyze Title 8, Code of Regulations, Section 9792(c), it is apparent that, as authorized by this rule of the Administrative Director, a medical provider may still claim fees above the fee schedule provided that fee claimed is reasonable, that the higher fee is justified by extraordinary circumstances related to the unusual

nature of the services rendered, and that the amount claimed is not in excess of the physician's usual fee.

IV.
PUBLIC POLICY AND EQUITY SUPPORTS A FINDING THAT FEES ABOVE THE OMFS ARE APPROPRIATELY REIMBURSED TO MEDICAL PROVIDERS IN CASES WHERE EXTRAORDINARY CIRCUMSTANCES ARE PROVEN

The OMFS was established to provide a basis for determining the maximum reasonable value of medical services. Bell v. Samaritan Med. Clinic, Inc. (1976) 60 Cal.App.3d 486 [41 Cal.Comp.Cases 415].) However, the values established by the OMFS must be adequate to ensure a reasonable standard of services and care for the injured worker. (Lab. Code, § 5307.1(f); Gould v. Workers' Comp. Appeals Bd. (1992) 4 Cal.App.4th 1059 [578 Cal.Comp.Cases 157].

Indeed the WCAB has broad equitable powers with respect to matters within its jurisdiction. (Dyer v. Workers' Comp. Appeals Bd. (1994) 22 Cal.App.4th 1376 [59 Cal.Comp.Cases 96]; Foundation Hospitals V. Workers' Compensation Appeals Bd. (1978) 83 Cal.App.3d 413 [43 Cal.Comp.Cases 785].) In a court's exercise of its equitable powers, it may consider any unjust or harsh results, and adopt means to avoid them. (See, e.g., Casas v. Thompson (1986) 42 Cal.3d 131, 141 [228 Cal.Rptr. 33, 720 P.2d 921].)

Where extraordinary circumstances are proven, an order awarding Lien Claimant's charges at the usual and customary rate as billed, fairly compensates the doctor for his extraordinary efforts in this difficult case, ensuring a reasonable standard of car for the injured worker and allowing an equitable result to be obtained by a doctor who takes a risk becoming involved an increasingly adversarial administrative process where he may not obtain full and adequate compensation him for his services.

///

V.

THE IBR PROCEDURE UNDER S.B. 863 DOES NOT DIVEST THE BOARD OF JURISDICTION OVER THE BILLING DISPUTES AT ISSUE IN THIS MATTER

The Court of Appeal has squarely addressed the issue of the operative date of the IBR dispute process under SB 863 in the matter of CIGA v. Workers' Comp. Appeals Board and Elite Surgical Centers, Econdido, L.P. (Filed 12/16/14 in D065072) (hereinafter referred to as "Elite Surgical Centers"), certified for publication and available online. The specific question presented to the Court of Appeal was:

> Does the Workers' Compensation Appeals Board (the Board) retain jurisdiction over a medical billing dispute pertaining to more than 300 consolidated claims, after the Legislature passed significant workers' compensation reform legislation that created a new administrative independent review process for the resolution of billing disputes?

In its analysis of this issue, and the legislative intent behind IBR, the Court points out the specific conflict at issue:

> This conflict between the language of section 84 of S.B. 863 (i.e., "This act shall apply to all pending matters, regardless of date of injury . . . ") and the reference to "enabl[ing] the independent review program to go into effect for injuries occurring on or after January 1, 2013" in section 139.5, subdivision (a)(2) renders the legislation ambiguous with respect to whether it was intended to apply to pending billing disputes such as the one at issue here, or rather, whether it was intended to apply only to disputes that arose with respect to injuries that occur after the effective date of the legislation, i.e., January 1, 2013

The Court then made a finding that the SB 893, with respect to the application of the IBR process, was ambiguous:

> After considering S.B. 863 as a whole, we conclude that this legislation is ambiguous with respect to whether the IBR process was intended to apply to pending billing disputes, or, rather, was intended to apply only prospectively, to new billing disputes that arise with respect to injuries that occur after the effective date of the legislation.

In addition to examining the legislative intent, the Court also recognized that the IBR provisions may apply only to cases which involve a date of injury on or after January 1, 2013.

> ...at least one other provision of the statute, Labor Code section 139.5, suggests that the IBR process was intended to apply only to disputes over medical treatment provided for injuries that occur on or after January 1, 2013.

The Court went on to observe the onerous IBR procedural requirements and concluded that:

> The new process by which billing disputes are to be resolved provides an even more compelling basis for our conclusion that the Legislature intended the IBR process to apply only to new disputes over billing.

The Court recognized that, like the case at bar, neither party-litigant has attempted to comply with the IBR requirements, leaving no practical solution:

> The practical effect of attempting to apply the new IBR review process to pending disputes, such as the one at issue in this case, would be that the parties would be left with *no dispute resolution process at all.* (Italics in original.)

In the case before the Court, Defendant, Hartford, has not initiated the IBR procedure by serving Lien Claimant an Explanation of Review, in the matter prescribed by the Administrative Director and which meets the detailed requirements of Labor Code §4603.3.[4]

---

[4] Labor Code, §4603.3 provides: Upon payment, adjustment, or denial of a complete or incomplete itemization of medical services, an employer shall provide an explanation of review in the manner prescribed by the administrative director that shall include all of the following:
(1) A statement of the items or procedures billed and the amounts requested by the provider to be paid.
(2) The amount paid.
(3) The basis for any adjustment, change, or denial of the item or procedure billed.
(4) The additional information required to make a decision for an incomplete itemization.
(5) If a denial of payment is for some reason other than a fee dispute, the reason for the denial.
(6) Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing. The explanation of review shall inform the medical provider of the time

Ultimately the Court of Appeal in the *Elite Surgical Centers* matter found:

> Our examination of the objectives to be achieved by the legislation, public policy, and the statutory scheme together leads us to conclude that S.B. 863 does not divest the Board of jurisdiction over pending billing disputes, thereby requiring that ongoing litigation involving such disputes be abandoned.
>
> We conclude that in creating the IBR process, the Legislature intended to establish a new dispute resolution procedure that would apply to disputes arising on or after the effective date of the legislation, and not to disputes like this one that were pending at the time the legislation went into effect.

The first lien claim filed in this case, which signaled the commencement of a billing dispute, was filed on May 18, 2012 (EAMS Doc ID 14283638). Like the billing disputes in the *Elite Surgical Centers* matter, this dispute was pending at the time SB 863 had been enacted (on January 1, 2013) and the procedures applicable to the IBR procedures (which begin upon the medical provider's bill being submitted to Defendant) cannot, as a practical matter, now be performed retroactively.

Like the parties in *Elite Surgical Centers*, there had been no compliance by Defendant with the requirements of IBR and neither party had attempted to pursue that administrative remedy, indeed such requirements had not even been published as of May 18, 2012, when the first lien was filed in this case.

Like the parties in *Elite Surgical Centers*, there is currently n*o viable process* by which the parties may obtain an IBR for the claims that have been pending for years. Nor is there any viable process, under IBR, for the parties to resolve the claim that extraordinary circumstances justify fees above the OMFS in this difficult spinal surgery case.

///

---

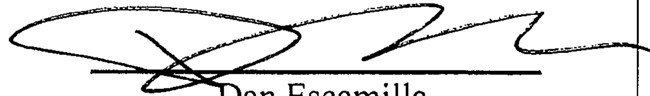
limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill pursuant to Section 4603.6.

CONCLUSION

For the reasons discussed herein, and for the reasons discussed herein, petitioner requests that the Board grant removal and find that Petitioner is entitled to fees above the OMFS under Rule 9792(c) and that the Board retains jurisdiction over the billing dispute in this case, and the IBR procedures are not applicable.

Respectfully submitted.

Dated: July 7, 2015



Dan Escamilla
LEGAL SERVICE BUREAU
Representative for Lien Claimant

VERIFICATION

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

I am the administrative representative LIEN CLAIMANT DAVID PAYNE, M.D., INC. and I am authorized to make this verification for and on each of their behalf, and I make this verification for that reason.

I have read the foregoing:

PETITION FOR REMOVAL

and know the contents thereof. The matters stated in the petition are true of my own knowledge except as to those matters which are stated on information and belief, and as to those matters I believe them to be true.

Executed on July 7, 2015 in the City of Los Angeles, State of California.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

DAN ESCAMILLA

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
28

LEGAL SERVICE BUREAU SANTA ANA
ELLIE PHAN
(714) 210-3500
THYLSB@GMAIL.COM

PROOF OF SERVICE BY MAIL
RE: CHARLES HOLDER

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

I am a citizen of the United States and a resident of and employed in the County of Orange, State of California. I am over the age of 18 and not a party to the within action or proceeding. My business address is 888 W. Santa Ana Blvd., Suite 100, Santa Ana, CA 92701.

On JULY 7, 2015 I served the within:

PETITION FOR REMOVAL

on the person(s) indicated below, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in the United States mail at Santa Ana, California, addressed as follows:

SEE ATTACHED MAILING LIST

Executed on JULY 7, 2015 in the City of Santa Ana, State of California.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Ellie Phan

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
28

MAILING LIST

WORKERS' COMPENSATION APPEALS BOARD (FILED VIA EAMS)

LAW OFFICES OF SAVIN & BURSK
10663 YARMOUTH AVE.
GRANADA HILLS, CA 91344

HARTFORD SACRAMENTO
P.O. BOX 14475
LEXINGTON, KY 40512

LYDIA NEWCOMB
P.O. BOX 2282
BREA, CA 92822

DAVID PAYNE, M.D., INC.
PO BOX 465
TUSTIN, CA 92761

///