WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

ROMANITA AYALA, ***Applicant,*** **vs.** **COUNTY OF LOS ANGELES/KING DREW MEDICAL CENTER, permissibly self-insured and adjusted by TRISTAR RISK MANAGEMENT,** ***Defendants.***	**Case No. ADJ1422645 (MON 0245005)** **(Marina del Rey District Office)** **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 said report which we adopt and incorporate, we will deny reconsideration.

Lien claimant contends that it is entitled to Labor Code section 5814 penalties. However, section 5814 provides for an increased payment of "compensation" when a benefit has been unreasonably delayed (Lab. Code, § 5814(a)) and "compensation" is payable only to an injured employee (Lab. Code, § 3207). Therefore, it is well-established that section 5814 penalties are not payable to a lien claimant, only to an injured employee. (*Vogh v. Workmen's Comp. Appeals Bd.* (1964) 264 Cal.App.2d 724, 728 [33 Cal.Comp.Cases 491, 494] (overruled on other grounds in *Adams v. Workers' Comp. Appeals Bd.* (1976) 18 Cal.3d 226, 230 [41 Cal.Comp.Cases 680]); see also, e.g., *Winters v. Workers' Comp. Appeals Bd.* (*Roa*) (2000) 65 Cal.Comp.Cases 1354 (writ denied); *Minter v. Workers' Comp. Appeals Bd.* (1996) 61 Cal.Comp.Cases 1491 (writ den.).)

Lien claimant contends that the Official Medical Fee Schedule (OMFS) does not establish a maximum fee for treatment self-procured by an injured employee when a defendant denies injury, citing to *Federal Mogul Corp. v. Workmen's Comp. Appeals Bd.* (*Whitworth*) (1973) 38 Cal.Comp.Cases 584

(writ den.) and *CNA Ins. Companies v. Workers' Comp. Appeals Bd.* (*Valdez*) (1997) 62 Cal.Comp.Cases 1145 (writ den.). However, although writ denied cases are citable authority as to the holdings of the Appeals Board panel decisions for which appellate review was summarily denied, they are not binding precedent and have no stare decisis effect. (*Farmers Ins. Group of Companies v. Workers' Comp. Appeals Bd.* (*Sanchez*) (2002) 104 Cal.App.4th 684, 689, fn. 4 [67 Cal.Comp.Cases 1545]; *Bowen v. Workers' Comp. Appeals Bd.* (1999) 73 Cal.App.4th 15, 21, fn. 10 [64 Cal.Comp.Cases 745].) We conclude that, at least under present law, *Whitworth* and *Valdez* are not persuasive authority to support an assertion that the maximum fee limits of the OMFS do not apply when injury has been denied.

Labor Code section 4600(a) provides that an employer must provide reasonably required medical treatment to an injured employee and, "[i]n the case of [the employer's] neglect or refusal reasonably to do so, the employer is liable *for the reasonable expense* incurred by or on behalf of the employee in providing treatment." (Italics added.) In turn, at all times relevant here, Labor Code section 5307.1(a)(1) provided that the Administrative Director shall adopt "an official medical fee schedule which shall establish *reasonable maximum fees* paid for medical services provided pursuant to this division." (Italics added; see also Lab. Code, § 5307.11 ["the official medical fee schedule shall establish *maximum reimbursement rates* for all medical services for injuries subject to this division provided by a health care provider … other than those specified in contracts subject to this section"] (italics added).)

Therefore, where industrial injury is ultimately found or stipulated, an employer who did not provide treatment because it had previously denied injury is liable only for "the reasonable expense" of the employee's self-procured treatment. (Lab. Code, § 4600(a).) Moreover, the OMFS as it existed at the time lien claimant's services were rendered established a maximum cap on what constitutes a "reasonable expense." (Former Lab. Code, § 5307.1(a)(1).)

We recognize that Administrative Director (AD) Rule 9792(c) sets forth specific circumstances under which a medical provider may recover more than the maximum amount deemed "reasonable" under the OMFS. AD Rule 9792(c) provides, in relevant part: "A medical provider or a licensed health care facility may be paid a fee in excess of the reasonable maximum fees [under the OMFS] 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." (Cal. Code Regs., tit. 8, § 9792(c).) However, AD Rule 9792 has not been amended since 1999, and it appears that this provision of Rule 9792(c) was based on the language of former Labor Code section 5307.1(b), which provided:

> "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."

However, Senate Bill (SB) 228, which became effective on January 1, 2004, repealed former section 5307.1 (Stats. 2003, chap. 639, § 34) and adopted a new section 5307.1 that did *not* include the former language enabling medical providers to seek a fee in excess of the OMFS (Stats. 2003, chap. 639, § 35).

Nevertheless, even if we assume that the language of Rule 9792(c) remains valid notwithstanding SB 228's removal of the corresponding language of former Labor Code section 5307.1,[1] we agree with the WCJ that lien claimant has not established "extraordinary circumstances" here.

Lien claimant also contends that the defendant in this case, the County of Los Angeles, King Drew Medical Center, must pay Labor Code section 4603.2(b)(2) interest at 10%, rather than the 7% allowed by the WCJ.

With respect to interest, Labor Code section 4603.2(b)(2) provides that, when a *non-governmental* employer fails to pay properly documented medical services within 45 days at the rates then in effect under Labor Code section 5307.1, the payment shall be increased by 15%, "together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the [provider's

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[1] But see *Mendoza v. Huntington Hosp.* (2010) 75 Cal.Comp.Cases 634, 640-641 (Appeals Board en banc) [regulation inconsistent with statute is invalid].

itemized billing]." However, Labor Code section 4603.2(b)(3) provides that "if the employer is a governmental entity," then payment "shall be made within 60 days after receipt of each separate itemization." Labor Code section 4603.2(b)(3) makes no reference to penalty or interest payments by governmental entities.

Even assuming, without deciding, that governmental entities must pay some interest under Labor Code section 4603.2(b)(3), the law is well-settled that post-judgment interest against a local government entity is limited to 7% per annum. (*California Federal Savings & Loan Assn. v. City of Los Angeles* (1995) 11 Cal.4th 342, 344-345, 347-348; *City of Clovis v. County of Fresno* (2014) 222 Cal.App.4th 1469; Cal. Const., art. XV, § 1.)

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For the foregoing reasons,

IT IS ORDERED that said Petition for Reconsideration be, and it hereby is, **DENIED.**

WORKERS' COMPENSATION APPEALS BOARD

DEPUTY

NEIL P. SULLIVAN

I CONCUR,

DEIDRA E. LOWE

DEPUTY

CRISTINE E. GONDAK

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

FEB 25 2014

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

LEGAL SERVICE BUREAU
LOS ANGELES CITY COUNCIL

NPS/ebc

WCAB CASE NO. ADJ1422645/MON0245005

ROMANITA AYALA **v.** **COUNTY OF LOS ANGELES KING DREW MEDICAL CENTER, permissibly self-insured and adjusted by TRISTAR RISK MANANGEMENT**

WORKERS' COMPENSATION ADMINISTRATIVE LAW JUDGE: **JACQUELINE A. WALKER**

REPORT AND RECOMMENDATION ON PETITION FOR RECONSIDERATION

I

SYNOPOSIS

1. Applicant's Occupation: Ultrasound Technician
   Applicant's Age: 46
   Date of Injury: 10/15/1997 – 10/15/1998
   Parts of Body Injured: Back, Fibromyalgia, Neck, Psyche, Shoulders and Wrists

2. Identity of Petitioner: **Lien Claimant, David Silver, M.D.** filed the Petition.
   Timeliness: The petition was timely filed.
   Verification: The petition was verified.

3. Date of issuance of Findings and Order: 12/20/2013

4. **Petitioner's contentions:**
   A. The WCJ erred in reducing the charges of the Lien Claimant's billing to the Official Medical Fee Schedule.
   B. The WCJ erred in awarding interest at the rate of seven percent.
   C. The WCJ erred in not awarding a penalty under Labor Code section 5814.
   D. The WCJ erred in denying costs.

II

RELEVANT FACTS

Applicant, Romanita Ayala, born , filed a claim alleging injury to her back, fibromyalgia, neck, psyche, shoulders and wrists during the period of October

15, 1997 through October 15, 1998, while working as an Ultrasound Technician for the County of Los Angeles. The claim was resolved by a Findings of Fact and Award for 100 percent that issued on January 11, 2011 by this WCJ.

This matter was set for lien trial on the lien of Dr. David Silver (hereafter referred to as "Lien Claimant"). The issues were identified as reasonableness of charges (applicability of the Official Medical Fee Schedule), interest, penalties and costs. Lien Claimant agreed to Defendants' bill review, except for the amounts allowed for Lidocaine. The parties jointly stipulated that the bill review should be modified to allow for $180.20 for the April 10, 2002 charge for prolonged services.

The Agreed Medical Examination reports from Seymour Levine, M.D., Richard Masserman, M.D., Jacob Esagoff, D.D.S. and Diane Weiss, M.D., along with three volumes of transcripts of Dr. Weiss' deposition testimony were admitted as Board exhibits. Defendants placed into evidence its benefit printout and bill review. Lien claimant placed into evidence medical reports from Dr. Silver and his Notices and Request for Allowance of Lien. All exhibits proffered were admitted into evidence with no objection made by the opposing side.

The sole witness was Louis Lozada. He testified on behalf of Defendants. Lien Claimant agreed that Mr. Lozada was an expert witness for the bill review. The parties stipulated that Mr. Lozada had reviewed all the applicable dates of service by Dr. Silver.

Mr. Lozada testified as summarized in the Minutes of Hearing and Summary of Evidence. As pertains to the Petition for Reconsideration, Mr. Lozada testified that his initial recommendation for appropriate payment of Dr. Silver's charges had increased from $19,309.64 to $19,512.79. The change was based upon stipulations that the parties reached on the day of trial regarding certain charges. He stated that the County previously paid $8,443.44. He recommended an additional payment of $11,068.75.

He characterized the treatment by Dr. Silver as office visits and injections. He stated, as billed, the doctor did not change the treatment provided to Applicant. His review of the medical reports and the billing did not contain any explanation that the treatment provided was anything beyond or above what was allowed by the Official Medical Fee Schedule.

He testified that the Official Medical Fee Schedule does not indicate that any of the treatment provided by Dr. Silver require any special equipment or constitutes special treatment. Nowhere in the Official Medical Fee Schedule that the treatment provided by Dr. Silver requires a state of the art facility or special equipment.

His review of the billing did not indicate anything unusual or extraordinary. He testified that it was his experience that 90 percent of the bills he has reviewed are billed beyond the Official Medical Fee Schedule. He stated that the mere fact that someone billed at their usual and customary charges does not necessarily mean that they expect to be paid beyond the Official Medical Fee Schedule. Most doctors bill based on their usual and customary charges because they have different types of patients – workers' comp, personal injury or health plans. He testified that doctors use usual and customary prices or charges because they can't use different prices for each patient.

He did read the explanation of extraordinary charges which was included with the lien. He doesn't know if it was attached to every date of service as they received the billing in bunches. The explanation is always the same. There is no specific reference contained in the explanation pertaining to any specific type of treatment. Based upon what was written, there were no provisions under the Official Medical Fee Schedule to allow for extraordinary charges.

He stated that he is familiar with the explanation or the language of how extraordinary circumstances may allow additional amounts, but he did not see that language in Dr. Silver's medical reports. If it were in the reports, there may have been a change.

There are instances where he has allowed for extraordinary circumstances and more amounts paid. Usually, he allows more if there was more time spent, prolonged research or more record review. If he can find it in the reports, then he would allow more. However, he did not find it in the reports of Dr. Silver.

He stated that he did change one code because it had been re-numbered with the updated Official Medical Fee Schedule. The recommended allowance for Lidocaine was based on one quantity as there was no indication of the quantity used on the billing.

A Findings of Facts and Orders Regarding Lien of David Silver, M.D., issued on December 20, 2013. It is from this Findings that Lien Claimant is aggrieved. Defendants have filed an Answer.

III

DISCUSSION

Lien Claimant is aggrieved because his charges were reduced using the Official Medical Fee Schedule. Lien Claimant asserts that he is entitled interest at 10 percent per annum. Lien Claimant states that he is entitled to a penalty for unreasonable delay pursuant to Labor Code section 5814. Finally, Lien Claimant contends that the he is entitled to costs.

It should be noted that the Opinion on Decision clearly states the basis for each issue decided. All medical reporting, transcript and documentary evidence relied upon is clearly identified. However, to the extent that the Opinion on Decision may seem skeletal, pursuant to Smales v. WCAB (1980) 45 CCC 1026, this Report and Recommendation cures that defect.

Attached to the Notice and Request for Allowance of Lien is a document entitled "Explanation of Extraordinary Circumstances Required by Labor Code §5307.6(b) to Justify Fees in Excess of Those Set Forth in the Official Medical Fee Schedule" (hereafter referred to as "Explanation of Extraordinary Circumstances"). Based upon the testimony of Mr. Lozada, this document was attached to the billing submitted to Defendants for payment.

Labor Code §5307.6 pertains only to medical-legal expenses. As Lien Claimant provided treatment to Applicant, his reliance on this section is misplaced. This Labor Code section does not support his contention that he is entitled to more than Official Medical Fee Schedule.

Notwithstanding the title of the document, in his Petition for Reconsideration, Lien Claimant cites Title 8, Code of Regulation §9792.5(c), as the basis for his assertion that he is entitled to more than the Official Medical Fee Schedule. The Regulation section number appears to be clerical error. It appears from the text quoted in the Petition that Lien Claimant is referring to Title 8, Code of Regulation §*9792(c)*.

Under Title 8, Code of Regulation §9792(c), in order to receive payment more than the Official Medical Fee Schedule, the requested fee must be reasonable, itemized and justified with an explanation of extraordinary circumstances related to the unusual nature of the services rendered. The Explanation of Extraordinary Circumstances constitutes Lien Claimant's only evidence to support payment of his billing outside the Official Medical Fee Schedule. It is a declaration made under penalty of perjury by Dr. Silver. (It is noted that the Board's copy does not contained a signature, but that is a cureable defect.) He states that because he operates from a state-of the art facility, the medical services rendered are "unusual". In addition, the doctor defines the "extraordinary circumstances" as the costs of overhead and other expenses incurred in operating and maintaining the facility. He declares that these costs associated with the medical services for the patient are significantly higher than other medical providers. He also states that the "unusual circumstances" also include multitude of symptoms which are all related to his (sic) industrial injury and extensive coordination efforts of medical treatment. Finally, he notes additional staffing resources for billing because of workers' compensation.

The Explanation of Extraordinary Circumstances does not support Lien Claimant's contention that he is entitled to payment in the excess of Official Medical Center. He does not elaborate why his facility is considered "state of the art". There is not any description of equipment, services, products used, technology, etc., that explains why it is unusual compared to other similar services. There is no explanation as to why the services given to this particular Applicant is unusual (other than the fact it occurred at his facility). While it is true Applicant had multiple parts of body involved in her industrial injury that is not unusual in workers' compensation. There is no identification of any particular treatment course or regime, specific to this applicant, in this declaration. The Explanation of Extraordinary Circumstance appears to be boilerplate and insufficient to warrant additional fees beyond the Official Medical Fee Schedule on its own.

As noted above, Lien Claimant agreed that the defense witness, Louis Lozada, was a bill review expert. His expert testimony was credible, knowledge base, persuasive and unrebutted. He testified that none of the treatment billed required any special treatment or equipment. He could not identify from the billing or the medical reporting

provided by Lien Claimant, any treatment that was unusual or extraordinary. In short, his testimony, supported the finding that the Official Medical Fee Schedule is the appropriate determination of the reasonableness of Dr. Silver's charges.

Lien Claimant also contends that the appropriate interest rate is 10 percent per annum. It was found that 7 percent is the correct rate for the interest. Defendant is the County of Los Angeles which is a public entity. Defendant is exempt from the ten percent interest rate as forth in Code of Civil Procedure section 685.010. Instead, Defendant is held to the constitutionally mandated rate of seven percent per annum.

Lien Claimant asserts that he is entitled to penalty pursuant to Labor Code section 5814 and costs. The costs are primarily based upon the premature filing for a lien conference and informal settlement efforts prior to the resolution of the case in chief. In addition, Lien Claimant did not present any evidence at trial regarding his petition.

Penalty was allowed pursuant to Labor Code section 4603.2 for Defendant delay in payment of the undisputed amounts. Labor Code section 5814 penalty is not applicable to Lien Claimant. Applicant may have a basis for asserting a penalty pursuant to Labor Code section 5814, but Lien Claimant's remedy is pursuant to Labor Code section 4603.2.

IV
RECOMMENDATION

It is respectfully recommended that Lien Claimant's Petition for Reconsideration be denied for the reasons stated above.

DATED: January 22, 2014

Jacqueline A. Walker

JACQUELINE A. WALKER
Workers' Compensation Administrative Law Judge

Filed and Served on the above date by mail/email on:
LSB/LEGAL SERVICE BUREAU
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