

# INTER-OFFICE MEMORANDUM

TO: ALL ATTORNEYS/CLIENTS  
FROM: JOE TRUCE  
DATE: August 16, 2004  
RE: IS THERE LIFE AFTER KUNZ?

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An Appeals Board Panel in the case of Garbini v. Macy's West (Decision after Reconsideration) resolved this question with a resounding "yes".

In Garbini the Board reversed the Workers' Compensation Judge (WCJ) who had allowed a lien claim by a surgery center in full.<sup>1</sup>

In reaffirming the Board's en banc in Kunz v. Golden Eagle Insurance Company (2002) 31 CWCR 12; 67 CCC 1588 (WCAB en banc) the Board once again reaffirmed the doctrine as set forth in Kunz that when the reasonableness of a facility fee is in issue defendants can produce evidence that (1) the fee billed is greater than the fee the lien claimant usually accepts, or (2) the facility fee claimed is greater than that usually accepted by other providers (including in-patient providers) in the general area.

The doctrine as enunciated by the Board in Kunz is alive and well.



WJT

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<sup>1</sup>The Garbini case is reported at 32 CWCR 134.

**KEGEL, TOBIN & TRUCE**  
**MEMORANDUM**

**TO:** ALL ATTORNEYS/CLIENTS

**FROM:** JOE TRUCE

**DATE:** December 18, 2002

**RE:** LANDMARK EN BANC DECISION BY WCAB ON LIEN  
CLAIMS - NOW THE FUN BEGINS

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I am enclosing an en banc decision by the Board in the case of Scott Kunz v. Patterson Floor Coverings, Inc.; and Golden Eagle Insurance Co. which is certainly a landmark decision for defendants as to lien claims by medical providers including pharmacies.

When Merle Rabine took over as a chairman of the Appeals Board, each en banc decision of the Board contains a footnote advising the workers' compensation community that "the Board's en banc decisions are binding precedent on all Board panels and WCJ's..."<sup>1</sup>

Prior to January 1, 2003 only the DIA Policy and Procedural Manual contained a mandate as to the legal effect of en banc decisions of the WCAB.

Not surprisingly, the proposed WCAB Rules (to take effect on January 1, 2003) contain a WCAB rule mandating that all en banc decisions by the Board are binding on all workers' compensation judges.

Chairman Rabine should be applauded by his attempt to obtain uniformity of law in the workers' compensation community.

The Board's en banc decision in Kunz is a devastating blow to almost all lien claimants who charge in excess of the Medical Fee Schedule<sup>2</sup> and also to those medical providers who provide medical services and/or pharmaceuticals to patients under group medical policies (such as Blue Cross) or pursuant to Medicare and/or Medi-Cal.

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<sup>1</sup>The above footnote appears on page 2 of the Kunz decision.

<sup>2</sup>Which in today's environment includes almost all medical providers or there would not be any need for bill review companies.

MEMO TO ALL ATTORNEYS/CLIENTS  
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NOW THE FUN BEGINS

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The important issues decided by the Board in Kunz are as follows:

1. Payment of medical treatment and/or medical bills in an admitted industrial injury case is guided by Labor Code §4603.2. For years we have been arguing that unless a medical provider fully complies with Labor Code §4603.2, the defendant does not have liability to pay the medical bills and/or charges. The Board has now confirmed this in Kunz as follows:

**"...the provisions of Section 4603.2 do not apply unless the prerequisites to this section's application have been met, i.e., the medical treatment in question must have been 'provided or authorized by the treating physician selected by the employee or designated by the employer (pursuant to Section 4600); and the medical providers billing to the defendant must have been 'properly documented' with an 'itemized billing together with any required reports and any written authorization for services that may have been received;..."**

Despite the protests of lien claimants, the receipt of the medical bill is not enough to give us liability under Labor Code §4603.2. The medical provider must enclose all "required documents." Also any charges that exceed the Official Medical Fee Schedule by a medical provider (which basically means all charges) must also be accompanied by "an itemization and explanation for the excess charge."<sup>3</sup>

An explanation by the medical provider that their charges exceed the Fee Schedule because of their "increased overhead" is no longer legally valid, as the law (Labor Code §5307.1) mandates that all medical providers who charge in excess of the Medical Fee Schedule must contemporaneously provide "an explanation of extraordinary circumstances related to the unusual nature of the medical services rendered..."

As almost all medical providers charge in excess of the Medical Fee Schedule and no medical providers explain that they are charging more than the Fee Schedule because of extraordinary circumstances or the unusual nature of the medical services rendered, it would appear that the Board in Kunz has indicated that since these billings are not properly documented Labor Code §4603.2 would not apply and we would not have liability to pay the medical bill.

MEMO TO ALL ATTORNEYS/CLIENTS

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<sup>3</sup>Administrative Rule 9792.5

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2. If you thought the above was a shot across the bow of the lien claimants, the next mandate of the Kunz decision basically sinks the entire ship.

Labor Code §5307.1<sup>4</sup> provides as follows:

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

Therefore, if the usual and customary charge of a physician and/or medical provider is even below the Official Medical Fee Schedule, the provider still cannot charge in excess of his usual fee.

For years medical providers and pharmacies have argued that their usual and customary charges have to be determined by the charges that they send to insurance companies and claims administrators in workers' compensation cases - even though these charges greatly exceed the Fee Schedule.

The Board has totally shot down this argument as follows:

**"In determining...reasonableness...the Board may take into consideration a number of factors, including but not limited to the following: the medical providers usual fee and the usual fee of other medical providers in the same geographical area, which means the fee usually accepted, not the fee usually charged;...including contractually negotiated fees...and the fee usually accepted by other providers in the same geographical area..."**

Although the Kunz case concerned fees charged by an outpatient surgery facility, the Board's decision in Kunz applies to all medical providers and lien claimants.

Therefore, in determining the usual and customary charge of a particular medical provider under the Kunz decision, it is now relevant as to whether or not the particular medical provider does business with Blue Cross, Medi-Cal; Medicare, Aetna Health or other group medical carriers and their usual fee may well be determined by what they accept as payment in full by these group health carriers or other payors. In my opinion, this is a devastating blow to the so-called "**usual and customary charges**" of today's medical providers, as we can now seek to discover what these medical providers

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<sup>4</sup>A copy of Labor Code §5307.1 is attached.

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are receiving from non-workers' compensation payors such as Blue Cross, Medi-Cal, Medicare, etc.

3. When we negotiate settlements with medical providers, we are usually presented with an argument that we cannot contest the reasonableness of the charges, as our client did not timely object to a medical treatment charge and/or lien. However, as a final blow to this argument by lien claimants, the Board has held as follows:

**"...Under Section 4603.2, a defendant's failure to specifically object to a medical treatment lien claim on the basis of reasonable medical necessity (or any other basis) does not affect a waiver of that objection..."**

I am enclosing a copy of a form objection I have prepared to a claim for reimbursement by a pharmacy.

The Kunz decision certainly brings back fairness in evaluating the reasonableness of medical and/or pharmaceutical charges.



WJT:dab

Attach: Kunz decision  
§5307.1  
Form objection

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WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

SCOTT KUNZ,

*Applicant,*

vs.

PATTERSON FLOOR COVERINGS, INC.;  
and GOLDEN EAGLE INSURANCE CO.

*Defendants.*

Case No. SJO 0224503

OPINION AND DECISION  
AFTER RECONSIDERATION  
(EN BANC)

On October 22, 2002, the Board granted reconsideration of the Findings and Order issued on August 9, 2002, in order to further study the factual and legal issues raised in the petition filed by lien claimant, Alpine Surgery Centers, LP, dba Silicon Valley Surgery Center ("Alpine"), an outpatient surgical facility.

In the August 9, 2002 decision, the workers' compensation administrative law judge ("WCJ") found that applicant, Scott Kunz, sustained industrial injury to his left knee on February 3, 2000, while employed as a carpet installer by Patterson Floor Coverings, Inc., the insured of Golden Eagle Insurance Company ("Golden Eagle"). The WCJ, however, disallowed Alpine's lien claim in the amount of \$7,902.00, which represented the balance of Alpine's "facility fee" bill relating to applicant's April 4, 2001 left knee surgery, after Golden Eagle had paid \$1,810.00 on the bill, as recommended by a bill review service. In disallowing the lien, the WCJ stated, among other things, "there has been absolutely no medical evidence offered, and no testimony presented, to establish that the knee surgery ... was reasonably required to cure or relieve from the effects of the industrial injury."<sup>1</sup>

<sup>1</sup> Restitution of the previously paid \$1,810.00 was neither requested nor ordered.

1 In its petition for reconsideration, Alpine contended in substance: (1) under Labor Code  
2 section 4603.2,<sup>2</sup> if a defendant objects to any portion of a medical treatment bill, it must advise the  
3 medical provider of the items being contested and the reasons for contesting these items, and, if a  
4 bill reviewer does not recommend payment as billed, the bill reviewer must provide “a specific  
5 explanation as to why the reviewer altered the procedure code or amount billed and the specific  
6 deficiency in the billing or documentation that caused the reviewer to conclude that the altered  
7 procedure code or amount recommended for payment more accurately represents the service  
8 performed;” (2) in determining a medical treatment lien claim, the Board is limited to resolving  
9 the specific objections made to the billing by the defendant and, here, Golden Eagle did not object  
10 to Alpine’s charges on the basis that the April 4, 2001 left knee surgery was not medically  
11 required; (3) at trial, Golden Eagle failed to rebut the testimony Alpine offered regarding the  
12 appropriateness of the billing in this case; and (4) outpatient surgery centers are not subject to the  
13 Official Medical Fee Schedule, and facility fees for such centers are reasonable if they do not  
14 exceed the center’s usual and customary charges and are consistent with the charges of similarly  
situated providers in the same geographic area.

15 Golden Eagle filed an answer to Alpine’s petition for reconsideration.

16 Because of the important legal issues presented, and in order to secure uniformity of  
17 decision in the future, the Chairman of the Board, upon a majority vote of its members, has  
18 reassigned this case to the Board as a whole for an en banc decision. (Lab. Code, §115.)<sup>3</sup> Based  
19 on our review of the relevant statutes, regulations, and case law, we conclude:

20 (1) under section 4603.2, a defendant’s failure to specifically object to a medical treatment  
21 lien claim on the basis of reasonable medical necessity (or on any other basis) does *not*  
22 effect a waiver of that objection;

23  
24 <sup>2</sup> All further statutory references are to the Labor Code, unless otherwise noted.

25 <sup>3</sup> The Board’s en banc decisions are binding precedent on all Board panels and WCJs. (*Gee v. Workers’*  
26 *Compensation Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236, 239, fn. 6];  
WCAB/DWC Policy & Procedure Manual, Index No. 6.16.1.)

- 1 (2) the provisions of section 4603.2 do not apply unless the prerequisites to the section's  
2 application have been met, i.e., the medical treatment in question must have been  
3 "provided or authorized by the treating physician selected by the employee or  
4 designated by the employer [pursuant to section 4600]" and the medical provider's  
5 billing to the defendant must have been "properly documented" with an "itemized  
6 billing, together with any required reports and any written authorization for services that  
7 may have been received;"
- 8 (3) the Official Medical Fee Schedule applies to medical services provided, referred or  
9 prescribed by "physicians" at an outpatient surgical facility;
- 10 (4) the Official Medical Fee Schedule generally does not apply to outpatient surgery *facility*  
11 *fees*, however, such fees nevertheless must be "reasonable;" and
- 12 (5) in determining the reasonableness of an outpatient surgery facility fee, the Board may  
13 take into consideration a number of factors, including but not limited to the following:  
14 the medical provider's usual fee and the usual fee of other medical providers in the  
15 same geographical area, which means the fee usually *accepted*, not the fee usually  
16 *charged*; the fee the outpatient surgery center usually accepts for the same or similar  
17 services (both in a workers' compensation context and in a non-workers' compensation  
18 context, including contractually negotiated fees); and the fee usually accepted by other  
19 providers in the same geographical area (including in-patient providers).

### 20 BACKGROUND

21 Applicant sustained an admitted left knee injury on February 3, 2000.

22 On April 4, 2001, applicant had left knee surgery, performed by Michael Butcher, M.D., at  
23 Alpine's outpatient surgery center. Alpine billed for a total of \$9,712.00 for three procedures, i.e.,  
24 (1) \$4,856.00 for a knee arthroscopy - lateral and medial menisectomies (CPT Code 29880),  
25 (2) \$2,428.00 for a chondroplasty (debridement) knee arthroscopy (CPT Code 29877), and  
26 (3) \$2,428.00 for a knee synovectomy (CPT Code 29876).<sup>4</sup>

27 <sup>4</sup> The "CPT" codes are the Current Procedural Terminology codes of the American Medical Association.

1 At some time not established by the present record, Alpine submitted its billing to Golden  
2 Eagle.

3 Thereafter, Golden Eagle sent Alpine's billing to a bill review service. In a written  
4 "explanation of review" statement served on Alpine, the bill review service allowed a payment of  
5 \$1,810.00 for the first procedure, which, it asserted, was the usual, customary and reasonable rate  
6 in Alpine's geographic area. The bill review service did not allow any payment for the other two  
7 procedures, stating that they were being "denied according to the surgical record." The bill review  
8 service then issued a check to Alpine in the amount of \$1,810.00.

9 On January 17, 2002, Alpine filed a lien for the \$7,902.00 balance of its billing and, on  
10 February 13, 2002, it filed a declaration of readiness to proceed to trial on the generic issue of its  
11 "lien."

12 A mandatory settlement conference ("MSC") took place on April 25, 2002. At the MSC,  
13 Alpine and defendant generically placed the "lien" in issue.

14 At the June 25, 2002 trial, the issues framed were, in essence: (1) liability for the lien of  
15 \$7,902.00, representing the difference between the amount billed by Alpine and the amount  
16 allowed by the bill review service; (2) section 4603.2 penalties and interest to Alpine; and (3) a  
17 section 5814 penalty to applicant. The parties placed in evidence Alpine's \$9,712.00 billing, Dr.  
18 Butcher's operative report (but no other medical reports), the bill review explanation, a copy of the  
19 \$1,810.00 check paid, a U.S. Department of Labor report (apparently, to show that labor costs in  
20 Alpine's geographic area are high), and some pages of CPT codes. Also, Alpine presented the  
21 testimony of Steven F. Kanter, M.D., a "managing principal" at Alpine.

22 Dr. Kanter testified, in substance, that Alpine prepares a bill based on the procedures  
23 specified in the operative report, that the three billing codes used here involve different parts of the  
24 anatomy of the knee, that the fees charged here were those usually charged by Alpine, and that the  
25 fees charged were less than those generally charged by other providers in the same geographic area.  
26 He also stated that it was customary for providers to charge for secondary surgical procedures, but  
27 to reduce the charges for the secondary procedures by 50-percent.

1 On August 9, 2002, the WCJ issued his decision finding that Alpine had failed to establish  
2 a prima facie case of entitlement to reimbursement and disallowing the lien. As noted above, the  
3 WCJ's Opinion recited, among other things, that "there has been absolutely no medical evidence  
4 offered, and no testimony presented, to establish that the knee surgery ... was reasonably required  
5 to cure or relieve from the effects of the industrial injury."

### 6 DISCUSSION

#### 7 I. Where Section 4603.2 Applies, A Defendant's Failure To Timely Make Specific 8 Objections To A Medical Treatment Billing Does Not Result In The Waiver Of The 9 Objections.

10 We will first consider whether the WCJ properly disallowed Alpine's lien on the basis that  
11 it failed to present medical evidence to establish that the knee surgery was reasonably required.

12 Where a lien claimant (rather than the injured employee) is litigating the issue of  
13 entitlement to payment for industrially-related medical treatment, the lien claimant stands in the  
14 shoes of the injured employee and the lien claimant must prove by preponderance of the evidence  
15 all of the elements necessary to the establishment of its lien. (Lab. Code, §§3202.5, 5705; *Kaiser*  
16 *Foundation Hospitals v. Workers' Comp. Appeals Bd. (Martin)* (1985) 39 Cal.3d 57, 67 [50  
17 Cal.Comp.Cases 411, 418]; *Industrial Indemnity Co. v. Industrial Acc. Com. (Lohnes)* (1935) 2  
18 Cal.2d 397, 404-409 [20 IAC 311, 313-317]; *Hand Rehabilitation Center v. Workers' Comp.*  
19 *Appeals Bd. (Obernier)* (1995) 34 Cal.App.4th 1204, 1210 [60 Cal.Comp.Cases 289, 291-292];  
20 *Beverly Hills Multispecialty Group v. Workers' Comp. Appeals Bd. (Pinkney)* (1994) 26  
21 Cal.App.4th 789, 801 [59 Cal.Comp.Cases 461, 469-470].)

22 Alpine essentially contends, however: (1) Golden Eagle had an obligation under section  
23 4603.2 to timely and specifically state *all* of its objections to Alpine's lien, including any  
24 objection that applicant's knee surgery was not reasonably required; and (2) because Golden Eagle  
25 allegedly failed to object on the basis of reasonable medical necessity, it waived this objection  
26 and, therefore, Alpine had no burden to come forward with any proof regarding this issue.  
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1 We conclude that a defendant's failure to specifically object to a lien on the basis of  
2 reasonable medical necessity (or on any other basis) does not result in a waiver of that objection  
3 under section 4603.2. It is true that section 4603.2(b)(2) requires a defendant to advise the  
4 medical provider "of the items being contested [and] *the reasons for contesting these items.*" (Lab.  
5 Code, §4603.2(b)(2) (emphasis added).) Yet, nothing in section 4603.2 states or implies that the  
6 consequence of a defendant's failure to make any particular specific objection is that the  
7 defendant is thereafter precluded from raising that objection, or that the lien claimant is relieved  
8 of any portion of its obligation to prove by preponderance of the evidence all of the elements  
9 necessary to the establishment of its lien. To the contrary, the only potential consequences of a  
10 defendant's failure to timely state any given specific objection under section 4603.2 are: (1) the  
11 defendant may become liable for a ten-percent penalty and/or interest, accrued from the date the  
12 defendant received the lien claimant's bill, on the unpaid balance of the lien allowed by the Board  
13 (Lab. Code, §4603.2(b); *Boehm & Associates v. Workers' Comp. Appeals Bd. (Lopez)* (1999) 76  
14 Cal.App.4th 513 [64 Cal.Comp.Cases 1350]); and (2) the defendant may become liable for a  
15 section 5814 penalty to the applicant, if the defendant's failure to object and pay is unreasonable.  
16 (Lab. Code, §4603.2(b).)<sup>5</sup> Because these potential consequences can be serious, a prudent  
17 defendant will timely raise *all* specific objections, including (where appropriate) an objection that  
18 the treatment rendered was not reasonably required to cure relieve the effects of an industrial  
19 injury. (See, Lab. Code, §4600.) However, a defendant does not forever waive any specific  
20 objection(s) it does not make.

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26 <sup>5</sup> A defendant's failure to properly object under section 4603.2 may also subject it to audit penalties. (Cal. Code  
27 Regs., tit. 8, §§10108(e), 10111(a)(9).)

1 In reaching this conclusion, we are mindful of our decision in *Otis v. City of Los Angeles*  
2 (1980) 45 Cal.Comp.Cases 1132 (Board en banc). In *Otis*, we interpreted former section 4601.5,  
3 which had some similarities to section 4603.2.<sup>6</sup> We held, in substance, that former section 4601.5  
4 required a defendant to make a specific and non-conclusionary written objection to the  
5 reasonableness of any medical-legal bill within 60 days of its receipt and, if the defendant failed to  
6 do so, it was precluded from raising (and the Board was precluded from considering) the  
7 reasonableness of the medical-legal cost.

8 However, *Otis* does not compel a conclusion that, under section 4603.2, a defendant should  
9 be deemed to waive any objection to a medical treatment billing that was not specifically made,  
10 including (but not limited to) an objection that the treatment rendered was not reasonably required  
11 to cure relieve the effects of an industrial injury.

12 First, there are significant differences between medical-legal billings and medical treatment  
13 billings. A defendant may be liable for a medical-legal billing even where it is ultimately  
14 determined that there is no industrial injury or that the employee's claim is barred by the statute of  
15 limitations. (*Subsequent Injuries Fund v. Industrial Acc. Com. (Roberson)* (1963) 59 Cal.2d 842,  
16 843 [28 Cal.Comp.Cases 139, 139-140]; *Beverly Hills Multispecialty Group, Inc. v. Workers'*  
17 *Comp. Appeals Bd. (Pinkney)* (1994) 26 Cal.App.4th 789, 802 [59 Cal.Comp.Cases 461, 471];  
18 *Turudich v. Industrial Acc. Com.* (1965) 237 Cal.App.2d 455, 457-459 [30 Cal.Comp.Cases 316,  
19 318-319].) A defendant, however, will not be liable for a medical treatment billing if there was no  
20 industrial injury (Lab. Code, §4600) or if the injury claim is time-barred. (Lab. Code, §5404.)  
21 Also, because medical-legal cost claims generally are relatively simple, the policy adopted in *Otis*  
22 to largely remove such claims from the litigation process was appropriate. Claims for medical

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23 <sup>6</sup> Former section 4601.5 had provided, in relevant part, that unless payment of a medical-legal billing was made  
24 within 60 days of receipt, "that portion of the billed sum then unpaid shall be increased by 10 percent, together with  
25 interest thereon at the rate of 7 percent per annum." It further provided, among other things: "Where the employer  
within the 60-day period, contests the reasonableness and necessity for incurring such fees, services, and expenses,  
payment shall be made within 20 days of the filing of an order of the appeals board directing payment."

1 treatment costs, however, are not nearly so simple and straightforward.<sup>7</sup> Finally, the amounts in  
2 issue in medical treatment lien litigation are often significantly greater than the amounts involved  
3 in medical-legal lien litigation.

4 Second, the medical-legal cost provisions of section 4601.5 were repealed by the  
5 Legislature in 1984 (Stats. 1984, ch. 596, §3) and were replaced by sections 4620 et seq.  
6 Although, notwithstanding the repeal of section 4601.5, “[t]he reasoning of the *Otis* decision  
7 continues to be sound” in some respects (*American Psychometric Consultants, Inc. v. Workers’*  
8 *Comp. Appeals Bd. (Hurtado)* (1995) 36 Cal.App.4th 1626, 1640 [60 Cal.Comp.Cases 559, 569]),  
9 the fact remains that, since *Otis*, there have been “major revisions” and a “massive [legislative]  
10 effort to strengthen and clarify the perceived weaknesses” in the procedures pertaining to medical-  
11 legal billings. (*American Psychometric Consultants, Inc. v. Workers’ Comp. Appeals Bd.*  
12 (*Hurtado*), *supra*, 36 Cal.App.4th at pp. 1641, 1643 [60 Cal.Comp.Cases at pp. 570, 571].) In  
13 particular, under sections 4620 et seq., a defendant now can raise (and the Board can consider)  
14 certain objections to a medical-legal billing, even if those objections were *not* specifically raised  
15 within 60 days of the receipt of the billing. (Lab. Code, §4622(d) [“Nothing contained in this  
16 section shall be construed to create a rebuttable presumption of entitlement to payment of an  
17 expense upon receipt by the employer of the required reports and documents. This section is not  
18 applicable unless there has been compliance with Sections 4620 and 4621.”]; see also, *American*  
19 *Psychometric Consultants, Inc. v. Workers’ Comp. Appeals Bd. (Hurtado)*, *supra*, 36 Cal.App.4th  
20 at pp. 1641-1645 [60 Cal.Comp.Cases at pp. 569-573] [holding that a defendant is not liable for  
21 medical-legal costs under section 4622 unless there has been compliance with sections 4620  
22 (contested claim) and 4621 (medical-legal expenses reasonably, actually, and necessarily

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23 <sup>7</sup> For example, a defendant can be liable for the cost of treatment for a *non-industrial* condition, if the evidence  
24 establishes that such treatment is reasonably required to cure or relieve the effects of an *industrial* injury. (Lab. Code,  
25 §4600; *Braewood Convalescent Hospital v. Workers’ Comp. Appeals Bd. (Bolton)* (1983) 34 Cal.3d 159,165-166 [48  
26 Cal.Comp.Cases 566, 570]; *Granado v. Workmen’s Comp. Appeals Bd.* (1968) 69 Cal.2d 399, 405-406 [33  
27 Cal.Comp.Cases 647, 652]; *Abdala v. Aziz* (1992) 3 Cal.App.4th 369, 376 [57 Cal.Comp.Cases 94, 97]; *Dorman v.*  
*Workers’ Comp. Appeals Bd.* (1978) 78 Cal.App.3d 1009, 1020 [43 Cal.Comp.Cases 302, 309]; *Vela v. Workmen’s*  
*Comp. Appeals Bd.* (1971) 22 Cal.App.3d 513, 520-521 [36 Cal.Comp.Cases 807, 812-813].)

1 incurred)]; *Del Rio v. Quality Hardware* (1993) 58 Cal.Comp.Cases 147 (Board en banc); *Apex*  
2 *Medical Group v. Workers' Comp. Appeals Bd. (Real)* (1994) 59 Cal.Comp.Cases 743 (writ den.)

3 Nevertheless, although there has been no waiver of the issue of whether applicant's knee  
4 surgery was reasonably required, we will remand to allow the parties to present evidence (or reach  
5 a stipulation) regarding that issue. This is because, based on the generic "lien" issues framed by  
6 the parties at the MSC and trial (and based on the absence of any evidence in the record that  
7 Golden Eagle objected to the surgery on the ground it was not reasonably required), we conclude  
8 the parties (or, at least, Alpine) understandably did not anticipate that this question might be in  
9 issue.

## 10 II. The Provisions Of Section 4603.2 Apply Only Where Its Prerequisites Have Been Met.

11 In any event, it is not clear that section 4603.2 even applies to Alpine's lien claim. Before a  
12 lien claimant can invoke the provisions of section 4603.2, it must establish that the prerequisites  
13 to that section's application have been met.

14 First, section 4603.2 does not apply unless the medical treatment in question was "provided  
15 or authorized by the treating physician selected by the employee or designated by the employer  
16 [pursuant to section 4600]." (Lab. Code, §4603.2(a) & (b).)<sup>8</sup> Thus, the statute provides that  
17 defendants are potentially subject to penalties and interest only if they do not promptly pay (or  
18 contest) billings for medical treatment provided or authorized by the primary treating physician.<sup>9</sup>

19 However, there appears to be no similar legislative concern about other medical treatment.<sup>10</sup>

20 <sup>8</sup> See also, Cal. Code Regs., tit. 8, §9792.5(a)(5) & (b) [providing that, within 60 days, the defendant must pay  
21 or contest the billings of the "treating physician," with that term defined to mean "the one physician managing the care  
22 of the injured employee who has been selected by the employee pursuant to Labor Code section 4603.2"]; cf., Cal.  
23 Code Regs., tit. 8, §9784 [the employer shall promptly authorize the primary treating physician to provide all  
24 reasonably required medical treatment].

25 <sup>9</sup> We note that the primary treating physician must periodically report to the defendant, including providing  
26 treatment plans (Lab. Code, §§ 4061.5, 4603.2(a); Cal. Code Regs., tit. 8, §9785(d), (e), (f), & (g)) and, if a dispute  
27 arises over the treatment prescribed by a primary treating physician, the employee and the defendant must follow  
specific dispute resolution procedures. (Lab. Code, §4061, 4062.) There are no comparable provisions with respect to  
treatment rendered by or obtained from other physicians.

<sup>10</sup> This does not mean that a defendant is not liable for, and a lien claimant cannot seek payment for, any  
reasonably required medical treatment that is not "provided or authorized" by the primary treating physician. It merely  
means that the procedures and remedies of section 4603.2 are not applicable to such treatment.

1 Second, section 4603.2 applies only where the medical provider's billing to the defendant is  
2 "properly documented," i.e., the section does not apply unless the medical provider has provided  
3 the defendant with an "itemized billing, together with any required reports and any written  
4 authorization for services that may have been received." (Lab. Code, §4603.2(b).)

5 Here, Alpine did not present any evidence regarding who, if anyone, was applicant's  
6 properly designated primary treating physician. Further, assuming there was a properly designated  
7 primary treating physician, Alpine did not present any evidence regarding whether that physician  
8 performed or authorized the surgery. Moreover, the parties made no stipulations regarding these  
9 issues.<sup>11</sup>

10 Also, there are serious questions regarding whether Alpine submitted a "properly  
11 documented" and "itemized" billing to Golden Eagle. As discussed above, Alpine's billing merely  
12 consisted of three CPT codes, with three corresponding brief descriptions of three surgical  
13 procedures. From the CPT pages that Alpine offered in evidence, however, it appears the CPT  
14 codes utilized by Alpine relate only to the surgical procedures themselves (i.e., the services  
15 performed *by the physician*). Thus, it appears that Alpine's billing merely establishes why  
16 applicant was at the outpatient surgery center (and, very generally, what happened while he was  
17 there). In any event, Alpine's billing does *not* set forth what specific services it actually provided  
18 in connection with applicant's surgical procedures. For example, although Dr. Butcher's operative  
19 report reflects that applicant was given general anesthesia, Alpine's billing does not reflect whether  
20 it provided the anesthetic. Similarly, although Dr. Butcher's operative report reflects that various  
21 instruments and supplies were used (e.g., a Stryker arthroscope, a Mitek thermal radio frequency  
22 probe, a shaver, mechanical instruments, a pain pump catheter, Steri-Strips, sterile dressing, a  
23 6-inch Ace bandage, and crutches), Alpine's billing does not reflect whether it provided these  
instruments and supplies. Also, although it might be inferred that Alpine provided the operating

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24 <sup>11</sup> Although the medical reports filed with the recently submitted stipulations with request for award suggest that  
25 Dr. Butcher (who performed the April 4, 2002 left knee surgery) was applicant's primary treating physician, these  
26 reports are not presently in evidence. (Cal. Code Regs., tit. 8, §10600 ["The filing of a document does not signify its  
27 receipt in evidence."].)

1 room and recovery room, the time period that these rooms were in use for applicant, and the rates  
2 at which these rooms were charged, are not specified. Further, Alpine's billing does not specify  
3 what medical support staff (other than physicians) Alpine provided during the course of the pre-  
4 operative preparations, the operation itself, or the post-operative recovery (and it does not specify  
5 the time expended and the rate(s) charged for any medical support staff).

6 Of course, where the Board's record is not adequately developed to permit the reasoned  
7 resolution of the issues before it, it may direct the further development of the record. (See, Lab.  
8 Code, §§133, 5701, 5906, 5908; *Kuykendall v. Workers' Comp. Appeals Bd.* (2000) 79  
9 Cal.App.4th 396, 403-406 [65 Cal.Comp.Cases 264, 268-269]; *Tyler v. Workers' Comp. Appeals*  
10 *Bd.* (1997) 56 Cal.App.4th 389, 392-395 [62 Cal.Comp.Cases 924, 926-928]; *Raymond Plastering*  
11 *v. Workmen's Compensation Appeals Bd. (King)* (1967) 252 Cal.App.2d 748, 753 [32  
12 Cal.Comp.Cases 287, 291]; *West v. Industrial Acc. Com. (Best)* (1947) 79 Cal.App.2d 711, 719  
13 [12 Cal.Comp.Cases 86, 89].) Here, for the reasons outlined above, the record is not adequately  
14 developed for us to conclude whether section 4603.2 applies to Alpine's lien, so we will remand  
15 the matter for development of the record.

16 **III. The Official Medical Fee Schedule Applies To Medical Services Provided, Referred Or  
17 Prescribed By "Physicians" At An Outpatient Surgical Facility.**

18 Alpine asserts that outpatient surgery centers are not subject to the Official Medical Fee  
19 Schedule under any circumstances. It also asserts that fees for such centers are reasonable if they  
20 do not exceed the center's usual and customary charges and are consistent with the charges of  
21 similarly situated providers in the same geographic area.

22 We do not agree (if Alpine is so asserting) that the Official Medical Fee Schedule is  
23 entirely inapplicable to *all* services performed at an outpatient surgery center.

24 Administrative Director Rule 9791 (Cal. Code Regs., tit. 8, §9791 states, in relevant part:

25 "Except as provided in this article, the Official Medical Fee  
26 Schedule applies to *all covered medical services provided, referred  
27 or prescribed by physicians* (as defined in Section 3209.3 of the  
Labor Code), *regardless of the type of facility in which the medical*

1            *services are performed*, including clinic and hospital-based  
2            physicians working on a contract basis.” (Cal. Code Regs., tit. 8,  
             §9791 (emphasis added).)

3            Moreover, page 1 of the General Instructions of the Official Medical Fee Schedule states:

4            “Outpatient procedures and services which are included in this fee  
5            schedule and which are provided in the emergency room or  
6            operating room of a hospital *or in a freestanding outpatient  
             surgery facility* shall be reimbursed in accordance with this fee  
             schedule.” (Emphasis added.)

7  
8            Thus, medical services provided, referred or prescribed by physicians at an outpatient facility *are*  
9            covered by the Official Medical Fee Schedule<sup>12</sup> and, in general, the reasonable value of such  
10           medical services will be established by the relevant unit values and conversion factors. (See Cal.  
11           Code Regs., tit. 8, §§9791, 9791.1, 9792, 9792.1.) That is, to obtain a fee in excess of the  
12           reasonable maximum, the “medical service” provider must submit an itemization and (1) show that  
13           the requested fee is reasonable and is not in excess of the provider’s usual fee; and (2) explain the  
14           extraordinary circumstances, related to the unusual nature of the services rendered. (Lab. Code,  
             §§5307.1(b), 5307.6(b); Cal. Code Regs., tit. 8, §§9792(c), 9792.5(c).)

15           Here, it is not clear whether Alpine’s billing included the services of Dr. Butcher or any  
16           other physician. Accordingly, we will remand on that question.

17           **IV. The Official Medical Fee Schedule Generally Does Not Apply To Outpatient Surgery**  
18           **Facility Fees. However, Such Fees Nevertheless Must Be “Reasonable.”**

19           We do agree with Alpine, however, that outpatient surgery *facility fees* generally are not  
20           subject to the Official Medical Fee Schedule. Administrative Director Rule 9791 (Cal. Code  
21           Regs., tit. 8, §9791) provides, in relevant part:

22           “Nothing contained in this schedule shall preclude any hospital as  
23           defined in subdivisions (a), (b), or (f) of Section 1250 of the Health  
24           and Safety Code, or any surgical facility which is licensed under  
             subdivision (b) of Section 1204 of the Health and Safety Code, *or*

25           <sup>12</sup> Although section 5307.1(a)(1) specifically refers to medical facilities licensed under Health and Safety Code  
26           section 1250 (i.e., medical facilities to which patients are admitted for a 24-hour stay or longer), this language  
27           constitutes language of inclusion, not of exclusion and limitation.

1            *any ambulatory surgical center* that is certified to participate in the  
2 Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.)  
3 of the federal Social Security Act, or any surgical clinic accredited  
4 by the Accreditation Association for Ambulatory Health Care  
(AAAHC), from charging and collecting *a facility fee* for the use of  
the emergency room or operating room of the facility.” (Cal. Code  
Regs., tit. 8, §9791 (emphasis added).)

5  
6 Although Rule 9791 refers to a facility fee “for the use of the emergency room or operating room  
7 of the facility,” this language does not appear to specifically limit “facility fees” to emergency  
8 room or operating room fees. Rather, the term “facility fee” appears to include all services  
9 provided at an outpatient surgery center, *except* for the professional medical services provided,  
10 referred or prescribed by a surgeon, assistant surgeon, anesthesiologist, or other “physicians”  
11 within the meaning of section 3209.3 *et seq.* (Cal. Code Regs., tit. 8, §9791; see also, Lab. Code,  
12 §§5307.1(a)(2); 5307.21(a)(1) [effective January 1, 2003].) Thus, without now deciding the  
13 question, a “facility fee” might include charges for the operating room, the recovery room, nursing  
14 services, medicines, medical and surgical supplies, and medical apparatus. (See, Lab. Code,  
§§3209.5, 4600.)

15 **V. Factors To Be Considered In Determining Reasonableness Of A Facility Fee.**

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

23            We emphasize that the “usual fee” to which we refer is the fee usually *accepted*, not the fee  
24 usually *charged*, because that is an aspect of the economics of a medical provider’s practice in the  
25 current market. In the absence of persuasive rebuttal evidence from the defendant, the outpatient  
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1 surgery center's billing, by itself, will normally constitute adequate proof that the fee being billed is  
2 what the outpatient surgery center usually accepts for the services rendered (and that the fee being  
3 billed is also consistent with what other medical providers in the same geographical area accept).  
4 The defendant, however, may present evidence that the facility fee billed by the outpatient surgery  
5 center is greater than the fee the outpatient surgery center usually accepts for the same or similar  
6 services, both in a workers' compensation context and a non-workers' compensation context,  
7 including contractually negotiated fees. Similarly, the defendant may present evidence that the  
8 facility fee billed by the outpatient surgery center is greater than the fee usually accepted by other  
9 providers in the same geographical area, including in-patient providers. Although neither the  
10 contractually negotiated amount that an outpatient surgery center usually accepts nor the amount  
11 that in-patient providers usually accept will necessarily be determinative of what constitutes a  
12 "reasonable" facility fee, these factors nevertheless will be relevant to what constitutes a  
13 "reasonable" fee (particularly if the fee being billed is grossly disproportionate either to the  
14 contractually negotiated amount that the outpatient surgery center usually accepts or to the amount  
15 that in-patient providers usually accept for the same or similar services). Of course, if a defendant  
16 offers such rebuttal evidence, the outpatient surgery center is free to offer contrary evidence, and  
17 the Board will resolve the issue of the lien based on the most persuasive evidence in the record as a  
18 whole.

19 Accordingly, for all the reasons above, we will rescind the August 9, 2002 Findings and  
20 Order, and we will return this matter to the WCJ for further proceedings and a new decision  
21 consistent with our opinion.<sup>13</sup>

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26 <sup>13</sup> On remand, the WCJ should also act on the recently filed stipulations with request for award (which do not  
27 relate to Alpine's lien).

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For the foregoing reasons,

**IT IS ORDERED**, as the Decision After Reconsideration of the Board (En Banc), that the Findings and Order issued by the workers' compensation administrative law judge on August 9, 2002 be, and it hereby is, **RESCINDED** and that this matter is **REMANDED** to the workers' compensation administrative law judge for further proceedings and a new decision consistent with this opinion.

***WORKERS' COMPENSATION APPEALS BOARD (EN BANC)***

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*MERLE C. RABINE, Chairman*

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*WILLIAM K. O'BRIEN, Commissioner*

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*JAMES C. CUNEO, Commissioner*

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*JANICE J. MURRAY, Commissioner*

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*FRANK M. BRASS, Commissioner*

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

***SERVICE BY MAIL ON SAID DATE TO ALL PARTIES AS SHOWN ON THE OFFICIAL ADDRESS RECORD, EXCEPT LIEN CLAIMANTS BUT INCLUDING PETITIONING LIEN CLAIMANT.***

NPS/tab

KUNZ, Scott