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."[1]

[1] Restitution of the previously paid $1,810.00 was neither requested nor ordered.

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

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

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

(1) 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 on any other basis) does *not* effect a waiver of that objection;

---

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

[3] The Board's en banc decisions are binding precedent on all Board panels and WCJs. (*Gee v. Workers' 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.)

(2) the provisions of section 4603.2 do not apply unless the prerequisites to the 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 provider's 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;"

(3) the Official Medical Fee Schedule applies to medical services provided, referred or prescribed by "physicians" at an outpatient surgical facility;

(4) the Official Medical Fee Schedule generally does not apply to outpatient surgery *facility fees*, however, such fees nevertheless must be "reasonable;" and

(5) in determining the reasonableness of an outpatient surgery facility fee, the Board may take into consideration a number of factors, including but not limited to the following: the medical provider's 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*; the fee the outpatient surgery center usually accepts for the same or similar services (both in a workers' compensation context and in a non-workers' compensation context, including contractually negotiated fees); and the fee usually accepted by other providers in the same geographical area (including in-patient providers).

BACKGROUND

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

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

[4] The "CPT" codes are the Current Procedural Terminology codes of the American Medical Association.

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

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

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

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

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

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

On August 9, 2002, the WCJ issued his decision finding that Alpine had failed to establish a prima facie case of entitlement to reimbursement and disallowing the lien. As noted above, the WCJ's Opinion recited, among other things, that "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."

DISCUSSION

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

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

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

Alpine essentially contends, however: (1) Golden Eagle had an obligation under section 4603.2 to timely and specifically state *all* of its objections to Alpine's lien, including any objection that applicant's knee surgery was not reasonably required; and (2) because Golden Eagle allegedly failed to object on the basis of reasonable medical necessity, it waived this objection and, therefore, Alpine had no burden to come forward with any proof regarding this issue.

We conclude that a defendant's failure to specifically object to a lien on the basis of reasonable medical necessity (or on any other basis) does not result in a waiver of that objection under section 4603.2. It is true that section 4603.2(b)(2) requires a defendant to advise the medical provider "of the items being contested [and] *the reasons for contesting these items*." (Lab. Code, §4603.2(b)(2) (emphasis added).) Yet, nothing in section 4603.2 states or implies that the consequence of a defendant's failure to make any particular specific objection is that the defendant is thereafter precluded from raising that objection, or that the lien claimant is relieved of any portion of its obligation to prove by preponderance of the evidence all of the elements necessary to the establishment of its lien. To the contrary, the only potential consequences of a defendant's failure to timely state any given specific objection under section 4603.2 are: (1) the defendant may become liable for a ten-percent penalty and/or interest, accrued from the date the defendant received the lien claimant's bill, on the unpaid balance of the lien allowed by the Board (Lab. Code, §4603.2(b); *Boehm & Associates v. Workers' Comp. Appeals Bd*. (*Lopez*) (1999) 76 Cal.App.4th 513 [64 Cal.Comp.Cases 1350]); and (2) the defendant may become liable for a section 5814 penalty to the applicant, if the defendant's failure to object and pay is unreasonable. (Lab. Code, §4603.2(b).)[5] Because these potential consequences can be serious, a prudent defendant will timely raise *all* specific objections, including (where appropriate) an objection that the treatment rendered was not reasonably required to cure relieve the effects of an industrial injury. (See, Lab. Code, §4600.) However, a defendant does not forever waive any specific objection(s) it does not make.

///

///

///

///

///

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

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

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

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

[6] Former section 4601.5 had provided, in relevant part, that unless payment of a medical-legal billing was made within 60 days of receipt, "that portion of the billed sum then unpaid shall be increased by 10 percent, together with 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."

treatment costs, however, are not nearly so simple and straightforward.[7] Finally, the amounts in issue in medical treatment lien litigation are often significantly greater than the amounts involved in medical-legal lien litigation.

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

---

[7] For example, a defendant can be liable for the cost of treatment for a *non-industrial* condition, if the evidence establishes that such treatment is reasonably required to cure or relieve the effects of an *industrial* injury. (Lab. Code, §4600; *Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd*. (*Bolton*) (1983) 34 Cal.3d 159,165-166 [48 Cal.Comp.Cases 566, 570]; *Granado v. Workmen's Comp. Appeals Bd.* (1968) 69 Cal.2d 399, 405-406 [33 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].)

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

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

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

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

First, section 4603.2 does not apply unless the medical treatment in question was "provided or authorized by the treating physician selected by the employee or designated by the employer [pursuant to section 4600]." (Lab. Code, §4603.2(a) & (b).)[8] Thus, the statute provides that defendants are potentially subject to penalties and interest only if they do not promptly pay (or contest) billings for medical treatment provided or authorized by the primary treating physician.[9] However, there appears to be no similar legislative concern about other medical treatment.[10]

---

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

[9] We note that the primary treating physician must periodically report to the defendant, including providing treatment plans (Lab. Code, §§ 4061.5, 4603.2(a); Cal. Code Regs., tit. 8, §9785(d), (e), (f), & (g)) and, if a dispute 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.

[10] 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.

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

Here, Alpine did not present any evidence regarding who, if anyone, was applicant's properly designated primary treating physician. Further, assuming there was a properly designated primary treating physician, Alpine did not present any evidence regarding whether that physician performed or authorized the surgery. Moreover, the parties made no stipulations regarding these issues.[11]

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

---

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

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

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

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

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

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

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

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

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

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

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

Thus, medical services provided, referred or prescribed by physicians at an outpatient facility *are* covered by the Official Medical Fee Schedule[12] and, in general, the reasonable value of such medical services will be established by the relevant unit values and conversion factors. (See Cal. Code Regs., tit. 8, §§9791, 9791.1, 9792, 9792.1.) That is, to obtain a fee in excess of the reasonable maximum, the "medical service" provider must submit an itemization and (1) show that the requested fee is reasonable and is not in excess of the provider's usual fee; and (2) explain the 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).)

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

IV. The Official Medical Fee Schedule Generally Does Not Apply To Outpatient Surgery Facility Fees, However, Such Fees Nevertheless Must Be "Reasonable."

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

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

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

> *any ambulatory surgical center* that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited 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).)

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

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

Although facility fees are not subject to the Official Medical Fee Schedule, any facility fee still must be "reasonable." (Lab. Code, §4600.) In determining the reasonableness of a facility fee (as with any medical treatment charge that is not subject to the Official Medical Fee Schedule), the Board may take into consideration a number of factors, including but not limited to the medical provider's usual fee, the usual fee of other medical providers in the geographical area in which the services were rendered, other aspects of the economics of the medical provider's practice that are 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].)

We emphasize that the "usual fee" to which we refer is the fee usually *accepted*, not the fee usually *charged*, because that is an aspect of the economics of a medical provider's practice in the current market. In the absence of persuasive rebuttal evidence from the defendant, the outpatient

surgery center's billing, by itself, will normally constitute adequate proof that the fee being billed is what the outpatient surgery center usually accepts for the services rendered (and that the fee being billed is also consistent with what other medical providers in the same geographical area accept). The defendant, however, may present evidence that the facility fee billed by the outpatient surgery center is greater than the fee the outpatient surgery center usually accepts for the same or similar services, both in a workers' compensation context and a non-workers' compensation context, including contractually negotiated fees. Similarly, the defendant may present evidence that the facility fee billed by the outpatient surgery center is greater than the fee usually accepted by other providers in the same geographical area, including in-patient providers. Although neither the contractually negotiated amount that an outpatient surgery center usually accepts nor the amount that in-patient providers usually accept will necessarily be determinative of what constitutes a "reasonable" facility fee, these factors nevertheless will be relevant to what constitutes a "reasonable" fee (particularly if the fee being billed is grossly disproportionate either to the contractually negotiated amount that the outpatient surgery center usually accepts or to the amount that in-patient providers usually accept for the same or similar services). Of course, if a defendant offers such rebuttal evidence, the outpatient surgery center is free to offer contrary evidence, and the Board will resolve the issue of the lien based on the most persuasive evidence in the record as a whole.

Accordingly, for all the reasons above, we will rescind the August 9, 2002 Findings and Order, and we will return this matter to the WCJ for further proceedings and a new decision consistent with our opinion.[13]

///

///

///

///

[13] On remand, the WCJ should also act on the recently filed stipulations with request for award (which do not relate to Alpine's lien).

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)

MERLE C. RABINE, Chairman

WILLIAM K. O'BRIEN, Commissioner

JAMES C. CUNEO, Commissioner

JANICE J. MURRAY, Commissioner

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