WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

MARIA TAPIA,

Applicant,

vs.

SKILL MASTER STAFFING; and LIBERTY MUTUAL INSURANCE COMPANY,

Defendant(s),

SB SURGERY CENTER,

Lien Claimant.

Case No. ADJ 4564224
(LBO 0322121)

OPINION AND DECISION AFTER RECONSIDERATION
(En Banc)

INTRODUCTION

To further study the issues presented, we granted the petition of lien claimant SB Surgery Center (SB) for reconsideration of the Findings & Order issued by the workers' compensation administrative law judge (WCJ) on November 30, 2007. In that decision, it was found that "The reasonable value of the services of S.B. Surgery Center is $4,700.00, less credit for prior sums paid along with interest thereon." Prior to the lien trial, SB billed $23,529.00 for outpatient surgery center services it provided in connection with surgery performed on applicant's right wrist at SB's facility, and defendant paid $1,667.66, leaving a claimed balance by SB of $21,861.34.

SB contends that defendant did not present evidence of fees accepted for the same services by outpatient surgery centers in the same geographic area as described in the en banc decision of the Appeals Board in *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 Cal.Comp.Cases 1588 (*Kunz*), and that in the absence of such evidence from a defendant, *Kunz* requires that the full amount of an outpatient surgery center's lien be allowed as a reasonable fee.

Because of the importance of the legal issue presented, and in order to secure uniformity of decision in the future, the Chairman of the Appeals Board, upon a majority vote of its members,

assigned this case to the Appeals Board as a whole for an en banc decision. (Lab. Code, § 115.)[1]

We hold that, consistent with *Kunz*: (1) an outpatient surgery center lien claimant (or any medical lien claimant) has the burden of proving that its charges are reasonable; (2) the outpatient surgery center lien claimant's billing, by itself, does not establish that the claimed fee is "reasonable"; therefore, even in the absence of rebuttal evidence, the lien need not be allowed in full if it is unreasonable on its face; and (3) any evidence relevant to reasonableness may be offered to support or rebut the lien; therefore, evidence is not limited to the fees accepted by other outpatient surgery centers in the same geographic area for the services provided.

FACTS

On July 10, 2006, the WCJ approved a $73,000.00 compromise and release of applicant's claim that she had sustained a cumulative industrial injury from November 1999 to January 25, 2001 to various body parts, including her right wrist. The only issue remaining after the settlement was the lien claim of SB. As noted above, SB billed $23,529.00 for services it provided in connection with surgery performed upon applicant's right wrist at its facility, and defendant paid $1,667.66 of that bill, leaving a claimed balance by SB of $21,861.34.

As described in the Minutes of Hearing (minutes) of the lien trial on October 30, 2007, defendant earlier stipulated that applicant incurred industrial injury to her right wrist and there was no dispute that SB provided reasonable services in connection with the wrist surgery performed at its facility on April 9, 2002.[2] Thus, the only issue was the reasonable amount that should be allowed as a fee for the services provided. The minutes show that SB placed the following into evidence:

> "Lien Claimant's 1 – Report of S.B. Surgery Center operative report dated 4-9-02.

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[1] En banc decisions of the Appeals Board are binding precedent on all Appeals Board panels and WCJs. (Cal. Code Regs., tit. 8, § 10341; *City of Long Beach v. Workers' Comp. Appeals Bd.* (*Garcia*) (2005) 126 Cal.App.4th 298, 313, fn. 5 [70 Cal.Comp.Cases 109, 120, fn. 5]; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236, 239, fn. 6]; see also Gov. Code, § 11425.60(b).)

[2] The April 9, 2002 operative report of Steven Nagelberg, M.D., describes the surgical procedure as "a scaphocapitate fusion with hardware removal as well as bone grafting at the fusion site, i.e. a limited carpal arthrodesis."

Lien Claimant's 2 – Lien and billing of S.B. Surgery Center.

Lien Claimant's 3 – Two letters from CMS Network [SB's representative] dated 9-11-07 and 10-23-07.

Lien Claimant's 4 – Letter from Administrative Director of Divsion [*sic*] of Workers' Compensation, Richard Gannon, dated June 19, 2002.

Lien Claimant's 5 – A letter from Steven Siemers, Chief Judge of the Divsion [*sic*] of Workers' Compensation, dated October 15, 2003."

Defendant placed the following into evidence:

"Defendant's A – Excerpts from Coding Companion for Orthopedics-Upper: Spine & Above; Ingenix.

Defendant's B – Part B Answer Book from Medicare Billing Rules Part B.

Defendant's C – Ambulatory Payment Classification Guide Ingenix 2003.

Defendant's D – California Outpatient Surgery Center Fee Allowances per CCR Section 9789.33.

Defendant's E – California Commission on Health and Safety and Workers' Compensation [CHSWC] summary.

Defendant's F – California Inpatient Hospital Fee Schedule Comparisons for Cedars Sinai, Good Samaritan, and USC University Hospital.

Defendant's G – Information regarding Medicare rates.

Defendant's H – (For I.D. Only) PPO contract excerpts."[3]

Also, in lieu of receiving testimony from defendant's expert witness, Milt Kyle, the minutes reflect the parties' stipulation that he would have testified as follows:

"The average DRGs [Diagnostically Related Groups] for the inpatient hospital fee schedule for the three hospitals mentioned earlier that are in the exhibits, and those in the geographical area, would be $5,690.80. This would include an overnight stay. The time in the hospital would be 1.8 days. He calculated an average per diem or daily rate of $3,139.35. The new fee schedule for this procedure would be $1,770.34. That would apply only to injuries on or after 1-1-04. This procedure was prior to that; but if we were to use the new fee schedule, that is what this procedure would be worth. Medicare ASC [Ambulatory Surgical Center], which was

[3] All bracketed material in quotations is added; the parenthesis is in the original.

> used in calculating the new fee schedule, would be $832.49 for this procedure. The Medicare fee schedule for hospital based outpatient surgery centers would be $1,214.68 for this procedure. A comparable procedure under the CHSWC study Level 5 (which was this procedure's level) would be an average of $2,196. It is stipulated by all parties that the defendant paid $1,667.66 to S.B. Surgery Center. It is further stipulated that the time spent for this procedure was three hours in the operating room and 1.75 hours in the recovery room."

As can be seen, neither party presented information regarding fees accepted by other outpatient surgery centers in the same geographic area as evidence of a reasonable fee. With regard to SB's evidence, the operative report in Lien Claimant's Exhibit 1 confirmed that the surgical procedure was performed at SB's facility. Lien Claimant's Exhibit 2 showed the amount billed by SB for the services and items it provided. The two letters in Lien Claimant's Exhibit 3 evidence SB's participation in the case and include a request for documents, but offer nothing regarding the issue of the reasonable value of the services provided.[4] The letters in Lien Claimant's Exhibits 4 and 5 simply iterate that there was no Official Medical Fee Schedule (OMFS) in place for outpatient surgical centers at the time services were provided by SB in April 2002.

As in its petition, SB argued at trial that under *Kunz* its billing and lien claim information constituted prima facie evidence that the amount it claimed was a reasonable fee, and that the WCJ was obligated under *Kunz* to allow the full amount of the lien claim in the absence of evidence from defendant that outpatient surgery centers in the geographic region accepted a lesser fee for the services provided. Although defendant did not present evidence of what other outpatient surgery centers in the geographic region accept as a fee, it argued that the materials it submitted into evidence and the stipulation regarding Mr. Kyle's testimony showed that that the amount claimed by SB was unreasonable, and that a reasonable fee had already been paid.

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[4] SB makes no contention in its petition for reconsideration concerning the two letters included in Lien Claimant's Exhibit 3, and the reason for their submission into evidence is not described in the minutes.

Following the trial, the WCJ issued his decision as described above. In his Report and Recommendation on Petition for Reconsideration (Report), the WCJ explains how he determined the amount of the awarded fee, as follows:

> "It is important to note that the outpatient surgery center's total charges for the procedure at issue were $21,861.34. On its face the bill seems grossly inflated. One must consider the fact that all of this was *outpatient* surgery. The surgery center did not care for the patient beyond a relatively brief recovery time, namely 1.75 hours. The applicant had no overnight hospitalization. The total amount allowed pursuant to the in-patient fee schedule for hospitals in the same geographic area would be $5,698.80. That would include an overnight stay, and it would include 24 hour care which the applicant certainly wouldn't receive on an outpatient basis. The 2004 Fee Schedule for this procedure would be $1,770.34.
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> "The lien claimant asserts it can simply present its bill (presumably for **any** amount whatsoever), and if defendants cannot prove the amount the lien claimant *accepts* defendants must pay their *entire* bill, no matter how high the charges are. I strongly disagree. Defendants' evidence was more than sufficient under Kunz." (Emphasis in original, citation omitted.)

DISCUSSION

SB misunderstands the burden of proof in outpatient surgery center lien cases and it misconstrues our en banc decision in *Kunz*.

The essential question is whether SB's outpatient surgery center lien is "reasonable." (Lab. Code, § 4600; *Kunz, supra*, 67 Cal.Comp.Cases at p. 1598.) It is *not* a defendant's burden to prove that an outpatient surgery center's claimed fee is *not* reasonable. To the contrary, the outpatient surgery center has the affirmative burden of proving that its lien *is* reasonable, and it must carry this burden by a preponderance of the evidence. (Lab. Code, § 5705 ("[t]he burden of proof rests upon the party *or lien claimant* holding the affirmative of the issue" (emphasis added); Lab. Code, § 3202.5 ("[a]ll parties *and lien claimants* shall meet the evidentiary burden of proof on all issues by a preponderance of the evidence" (emphasis added).) Imposing the burden of proving the reasonableness of its charges upon the outpatient surgery center is consistent with the well-established general principle that a lien claimant has the burden of proving *all* of the elements necessary to the establishment of its lien. (*Kunz, supra*, 67 Cal.Comp.Cases at p. 1592; see also

Zenith Insurance Company v. Workers' Comp. Appeals Bd. (*Capi*) (2006) 138 Cal.App.4th 373, 376-377 [71 Cal.Comp.Cases 374, 376-377] ("In workers' compensation matters, the burden of proof rests on the party or lien claimant 'holding the affirmative of the issue.' (Lab. Code, §§ 5705, 3202.5.)"); *Boehm & Associates v. Workers' Comp. Appeals Bd.* (*Brower*) (2003) 108 Cal.App.4th 137, 150 [68 Cal.Comp.Cases 548, 557] ("The burden of proof of a lien is upon the lien claimant (Labor Code sec. 5705) who must establish his or her claim by a preponderance of the evidence."); *Hand Rehabilitation Center v. Workers' Comp. Appeals Bd.* (*Obernier*) (1995) 34 Cal.App.4th 1204, 1212-1213 [60 Cal. Comp. Cases 289, 291-292] ("A lien claimant … has the burden of proving by a preponderance of the evidence that the claim is industrial (§ 3202.5).").)[5]

If the parties do not agree on what constitutes a "reasonable" outpatient surgery center fee, the WCAB may take into consideration a number of factors in addressing the issue. (*Kunz, supra*, 67 Cal.Comp.Cases at p. 1598.) These include, but are not limited to, the provider's usual fee and the usual fee of other providers in the geographical area in which the services were rendered. (*Id*; see also, *Gould v. Workers' Comp. Appeals Bd.* (1992) 4 Cal.App.4th 1059, 1071 [57 Cal. Comp. Cases 157, 165].) In the absence of other evidence, an outpatient surgery center's billing may establish (1) what it usually accepts for the services rendered and (2) what other medical providers in the same geographical area usually accept. (*Kunz, supra*, 67 Cal.Comp.Cases at p. 1598.) Although the outpatient surgery center's billing can be prima facie evidence *on these two points*, the billing – by itself – does *not* establish that the claimed fee is "reasonable." (*Kunz, supra*, 67 Cal.Comp.Cases at p. 1599 ("neither the [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' [outpatient surgery center] fee.").)

Furthermore, rebuttal evidence may be presented on the question of the reasonableness of a lien claimant's billing, including but not limited to evidence: (1) that the outpatient surgery center actually accepts less for the same or similar services; (2) that other outpatient surgery centers in

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[5] In this case, the parties stipulated that applicant sustained industrial injury to her right wrist and that her right wrist surgery was reasonably required. In other cases, however, a lien claimant would also have the burden of proof on these issues, absent a stipulation or prior judicial finding.

the same geographical area accept less for the same or similar services; or (3) that inpatient hospitals or surgery centers in the same geographical area accept less for the same or similar services. (*Kunz, supra*, 67 Cal.Comp.Cases at p. 1599.) In particular, the fee charged by an outpatient surgery center will not be found to be "reasonable" if it is "grossly disproportionate" to the amount accepted by other outpatient and inpatient facilities in the same geographical area for the same or similar services. (*Id*.)

Although *Kunz* states that a defendant's rebuttal evidence may consist of what other inpatient or outpatient providers "accept" for the same or similar services (*Kunz*, *supra*, 67 Cal.Comp.Cases at p. 1598), this statement does not limit what rebuttal evidence may be presented. To the contrary, *Kunz* expressly declares that in determining the reasonableness of an outpatient surgery center fee, "the Board may take into consideration a number of factors, *including but not limited to*" the fee usually accepted by the lien claimant and other inpatient or outpatient providers. (*Id*. (emphasis added).) Therefore, in litigating the question of a reasonable outpatient surgery center fee, a defendant or lien claimant may present *any* relevant evidence concerning that issue.

In its petition, SB cites *Universal Building Services v. Workers' Comp. Appeals Bd.* (*Yturbe*) (2006) 71 Cal.Comp.Cases 655 (writ den.) (*Yturbe*) for the proposition that an outpatient surgery center's billing must be accepted as proof of a reasonable fee if a defendant does not present evidence of what other facilities "accept" for the same or similar services. Although "writ denied" cases are citable authority as to the holding of the Appeals Board in its underlying decision, they are not binding precedent and have no stare decisis effect. (E.g., *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].) Moreover, Appeals Board panel decisions may be overruled by the Board acting en banc. (Cal. Code Regs., tit. 8, § 10341; *MacDonald v. Western Asbestos Co*. (1982) 47 Cal.Comp.Cases 365, 366 (Appeals Board en banc).) We now expressly disapprove of *Yturbe* to the extent it suggests (1) that a defendant has the burden of proving that

the amount claimed by an outpatient surgery center is unreasonable; (2) that in the absence of rebuttal evidence from a defendant, an outpatient surgery center's billing must be allowed in full no matter how unreasonable it is on its face; or (3) that only the specific evidence mentioned in *Kunz* may be presented to rebut an outpatient surgery center lien claim. The outpatient surgery center has the burden of proof on its lien; the WCAB is *not* required by *Kunz* or any other case to allow the full amount of a billing which is unreasonable on its face; and the specific evidence mentioned in *Kunz* is *not* the only evidence that may be considered in determining whether the amount claimed is reasonable.

Here, in its attempt to carry its burden of proof on the issue of reasonableness, the only evidence SB presented was its $23,529.00 billing. Per the parties' stipulation at trial, SB provided three hours of operating room services and 1.75 hours of recovery room services.

Defendant, however, presented extensive rebuttal evidence, including stipulations as to what Mr. Kyle would have testified. Although there was not an official medical fee schedule covering *outpatient* surgery centers at the time SB provided services, there was such an OMFS for *inpatient* fees that was based upon various factors, including the applicable DRGs. (Cal. Code Regs., tit. 8, § 9792.1.)[6] Mr. Kyle's testimony established that, under the OMFS for inpatient providers, the "maximum reimbursement" for three hospitals in the same geographic area would have been $5,698.80, and that this $5,698.80 reimbursement rate would be for *1.8 days* in the hospital, including an overnight stay. Therefore, SB's $23,529.00 billing for its *outpatient* services – covering three hours of operating room and 1.75 hours of recovery room time – was over four times as great and nearly $18,000.00 more than the amount allowed by law for *inpatient* hospitals in the same area, even if substantially longer stays were involved.

In addition, the parties stipulated that Mr. Kyle would have testified that the Medicare fee schedule for the DRG codes involved would have allowed an outpatient surgery center that provided services at that time for the same procedure a fee of $1,214.68, or approximately 95%

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[6] DRG is the acronym for "Diagnosis Related Group," which is a classification scheme for hospital inpatient reimbursement. (See Cal. Code Regs., tit. 8, § 9789.21(i).)

less than the amount billed by SB. Similarly, the CHSWC study submitted by defendant shows an average fee of $2,196.00 for the same procedure. Finally, we observe that current Labor Code section 5307.1(c) provides that the maximum facility fee for an ambulatory surgical center "may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department," and that the current OMFS would allow $1,770.34 as a reasonable fee. (Lab. Code, § 5307.1(c); Cal. Code Regs., tit. 8, § 9789.30 et seq.)[7]

We recognize that section 5307.1(c) and the OMFS pertaining to outpatient surgery center fees did not go into effect until January 1, 2004, which was after the time that lien claimant provided its services. Therefore, neither section 5307.1(c) nor the OMFS, standing alone, is dispositive of the issue of what constitutes a reasonable fee for outpatient surgery center services before January 1, 2004. Nevertheless, it cannot be said that section 5307.1(c) and the current OMFS are irrelevant to the issue of a reasonable fee. To the contrary, section 5307.1(c) illustrates the Legislature's view of what constitutes a reasonable outpatient surgery center fee as of January 1, 2004, and provides one yardstick against which billings before that date may be measured. This is particularly true in this case because SB presented no evidence to explain the significant discrepancy between the amount allowed by the current schedule and the amount it billed.

In short, SB failed to carry its burden of proving that the $23,529.00 it billed for outpatient surgery center services was reasonable. The only evidence it presented bearing on the issue of reasonableness was the billing itself. Yet as discussed above, even if defendant had presented *no* rebuttal evidence, the most that SB's $23,529.00 billing could establish is that this is the amount that it and other providers in the same area usually accept for the services rendered; the billing by itself does *not* establish that the amount claimed is "reasonable." (*Kunz, supra*, 67 Cal.Comp.Cases at pp. 1598-1599.) Moreover, even absent rebuttal evidence from defendant, the amount billed would not have to be accepted if it was unreasonable on its face.

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[7] We only consider information received into evidence at trial, and give no weight to SB's hearsay assertions in its petition that "Defendant uses contracted rates and Medicare without painting the full picture," or that "to compare an outpatient surgery center to a hospital would be tantamount to comparing apples with oranges." Moreover, SB does not dispute that the *services* it provided are substantively comparable to those provided by an inpatient hospital for the same surgery.

Defendant, however, did present extensive rebuttal evidence. Mr. Kyle's stipulated testimony demonstrated that SB's $23,529.00 billing was over four times and nearly $18,000.00 more than the legally allowable amount for *inpatient* hospitals in the same geographic area for the same services – even if the patient stayed at the hospital for 1.8 days, which is substantially more than the three hours of operating room and 1.75 hours of recovery room services provided by SB in this case. Mr. Kyle's stipulated testimony further established that Medicare would have allowed a fee of $1,214.68 for the same outpatient surgery center services performed at the same time, which is approximately 95% *less* than what SB billed. Further, the CHSWC study offered by defendant shows an average fee of $2,196.00 for the same procedure.

Finally, current section 5307.1(c) and the current OMFS would allow $1,770.34 as a reasonable fee. Of course, section 5307.1(c) and the current OMFS first went into effect on January 1, 2004. Therefore, they are not directly applicable to SB's outpatient surgery center services, which were rendered in April 2002. Nevertheless, although section 5307.1(c) and the current OMFS cannot by themselves establish what constitutes a "reasonable" fee for services provided before their effective date, they do provide some measure of reasonableness, when considered in light of the evidence presented.

In the absence of evidence from SB affirmatively establishing that its outpatient surgery center charges of $23,529.00 were reasonable, the WCJ properly relied on the persuasive evidence submitted by defendant to determine that a fee of $4,700.00 is reasonable.

The decision of the WCJ is affirmed.

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For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Appeals Board (En Banc) that the Findings and Order of November 30, 2007 is **AFFIRMED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ Joseph M. Miller
JOSEPH M. MILLER, Chairman

/s/ James C. Cuneo
JAMES C. CUNEO, Commissioner

/s/ Frank M. Brass
FRANK M. BRASS, Commissioner

/s/ Ronnie G. Caplane
RONNIE G. CAPLANE, Commissioner

/s/ Alfonso J. Moresi
ALFONSO J. MORESI, Commissioner

/s/ Deidra E. Lowe
DEIDRA E. LOWE, Commissioner

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA
9/17/08

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

Maria Tapia
Manuel Aguirre
Reed Scuria
SB Surgery Center
CMS Network, Inc.

JFS/aml