TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Constitutional Provisions

Statutes

Regulations

COURT OF APPEAL
FOURTH APPELLATE DISTRICT, DIVISION ONE
STATE OF CALIFORNIA

CALIFORNIA INSURANCE GUARANTEE ASSOCIATION; AIU INSURANCE COMPANY; AMERICAN HOME ASSURANCE COMPANY; INSURANCE COMPANY OF THE WEST; EXPLORER INSURANCE COMPANY; SOLAR TURBINES, INC.; BAE SYSTEMS SHIP REPAIR; and ACE AMERICAN INSURANCE COMPANY,

Defendants and Petitioners,

v.

WORKERS' COMPENSATION APPEALS BOARD,

Respondent.

PETITION FOR WRIT OF REVIEW

INTRODUCTION - WHY REVIEW SHOULD BE GRANTED

On January 1, 2013, the California Legislature divested the respondent Workers' Compensation Appeals Board (Board) of jurisdiction to resolve medical billing disputes and mandated that such matters be resolved through a new administrative procedure. (Stats. 2012, ch. 363 (Sen. Bill No. 863); hereinafter, Senate Bill 863.) One month later on February 1, 2013, Clifford Levy, a workers' compensation administrative law judge in the Board's San Diego office, issued a decision relating to a consolidated medical billing dispute involving three commonly managed San Diego County ambulatory surgical center facilities. In that decision, the trial judge made findings of fact that a reasonable facility fee for arthroscopic knee, arthroscopic

shoulder and epidural injection procedures performed in San Diego County before January 1, 2004 is $5,207.85, $4,340.95, and $2,337.52 respectively, or the amount billed, whichever is less.

The petitioners sought reconsideration upon grounds that the Board did not have jurisdiction to resolve the medical billing dispute and that the three findings of fact were not supported by substantial evidence. The Board denied reconsideration on October 30, 2013.

The aggrieved parties now seek a Writ of Review pursuant to Labor Code section 5950 et seq. on grounds that the Board acted without or in excess of its powers and that the Board's decision is unreasonable and not supported by substantial evidence. Because of Senate Bill 863, the Board no longer has jurisdiction to determine medical billing disputes. Medical providers must instead pursue the new exclusive administrative remedy as provided by Senate Bill 863. Even if the Board does have jurisdiction to resolve billing disputes, there is no evidence to support the Board's three findings of fact as to what constitutes a reasonable ambulatory surgical center facility fee within the San Diego County market place.

FACTUAL AND PROCEDURAL BACKGROUND

A. The Parties and their Consolidated Medical Billing Dispute

The eight petitioners are (1) California Insurance Guarantee Association, (2) AIU Insurance Company, (3) American Home Assurance Company (as insurer for Wal-Mart Associates, Inc.), (4) Insurance Company of the West, (5) Explorer

Insurance Company, (6) Solar Turbines, Inc., (7) BAE Systems Ship Repair, Inc., (as insured by United States Fire Insurance Company and Security Insurance Company of Hartford), and (8) ACE Property and Casualty Company (hereinafter collectively referred to as Petitioners.)[1]

The respondent Board is a commission of the State of California.

The three real parties in interest are (1) Elite Surgical Centers, Escondido, L.P., (2) Elite Surgical Centers, Del Mar, L.P. and (3) Point Loma Surgical Center, L.P. (collectively Elite) with ambulatory surgery center (ASC) facilities within a 30-mile radius of each other in the western half of San Diego County. (Exhibits Filed in Support of Petition for Writ of Review (Exhibits) Vol. I, San Diego County map, Exhibit 1 at page 1.)[2]

The case involves Elite's consolidated billing disputes with Petitioners before the Board relating to services provided to injured workers before January 1, 2004.

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[1] In the proceedings below, American Manufacturers Mutual Insurance Company was a defendant. American Manufacturers Mutual Insurance Company was subsequently declared insolvent and ordered into liquidation and therefore no longer is a party. Petitioner California Insurance Guarantee Association now has liability for Elite's disputed medical bills previously sent to American Manufacturers Mutual Insurance Company.

[2] Exhibit 1 is a photograph of a San Diego County map with the three Elite ASCs marked with red pins. The blue pins are the 21 San Diego County hospitals, and the green pins are 19 other San Diego County ASCs.

In November of 2000, Elite increased its charges for ASC services. For example, instead of charging $4,100 for an arthroscopic knee procedure as it once did, Elite increased its average charge to $18,383.59. (Exhibits Vol. V, Reporter's Transcript (hereinafter "RT"), Exhibit 39 at pages 1008-1009 and 1023-1024; Exhibits Vol. I, Table from Rocky Gentner file, Exhibit 9 at page 66.) Petitioners disputed the reasonableness of Elite's increased charges paying only what they thought was appropriate. Elite sought to collect the disputed balance by filing Notices and Requests for Allowance of Liens with the Board's San Diego district office.

The Board's San Diego office was besieged with several thousand pending, but unresolved, Elite Liens for services rendered before January 1, 2004. In response, the Board issued several orders to consolidate Elite Liens to address the reasonableness of Elite's charges. The current proceeding arises from the most recent consolidation order issued on July 3, 2007. (Exhibits Vol. I, Order of Consolidation, Exhibit 2 at page 2.)

B. The Workers' Compensation System

The California Constitution vests the Legislature with plenary power to create and enforce a complete system of workers' compensation laws. A complete system includes the administration of such legislation to "accomplish substantial justice in all cases expeditiously, inexpensively, and without incumbrance of any character" which is "declared to be the social public policy of this State, binding upon all departments of the State government." (Cal. Const., Art. XIV, § 4.)

Division 4 of the Labor Code sets out an extensive regulated system for medical treatment of employees injured at work. (Lab. Code, § 3200 et seq.)[3] The administrative director is charged with the responsibility to adopt and revise periodically an official medical fee schedule (OFMS) that establishes a "reasonable maximum fee" paid for medical treatment provided to injured workers. (§ 5307.1.)

The OMFS establishes the reasonable maximum fee for services charged by each of the 21 San Diego hospitals for dates of admission during the period April 13, 2001 through December 31, 2003. (8 Cal. Code. Regs, § 9792.1, in effect 2001 through 2003.) On February 8, 2002, the State of California Commission on Health, Safety & Workers' Compensation published a study discussing increased costs and Board litigation arising from the anomaly that facility fees charged by ASCs were not then covered by the OMFS. (Exhibits Vol. I, Commission on Health, Safety and Workers' Compensation Study, Exhibit 5, at page 38.)

In 2003, the Legislature required the administrative director to provide for ASC facility fees within the OMFS for dates of service after January 1, 2004. (Stats. 2003, ch. 639 (SB 228), § 35.) The Legislature mandated that "the maximum facility fee for services performed in 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. (§ 5307.1, subd. (c).)

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[3] Further statutory references are to the Labor Code.

The administrative director published implementing regulations that set the maximum reasonable ASC facility fee to be 120% of the relative value standard promulgated by Medicare for the same services performed in a hospital outpatient department adjusted by local geographic inflation and wages (the "adjusted conversion factor"). (8 Cal. Code Regs., Article 5.3, § 9789.10 et seq., (hereinafter referred to as the "ASC OMFS").)

C. The ASC OMFS Billing and Payment Methodology

The ASC OMFS regulatory methodology applies an objective mathematic formula premised upon billing codes and relative values for services premised upon the American Medical Association's Current Procedural Terminology (CPT Codes) first developed in 1966. (§ 5307.1; 8 Cal. Code Regs., § 9789.30 et seq.) The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes. "Coders" input one or more CPT Codes on a Health Care Financing Administration ("HCFA") 1450 Uniform/Universal Billing Form 92 ("UB-92") to accurately describe all of the services provided. The CPT coding system does not consider subjective factors such as the claimed quality of the facility or its unique internal cost structure. Instead, all facilities are compensated on the same objective CPT code basis. (Exhibits Vol. IV, RT, Exhibit 37 at pages 793-794; Exhibits Vol. VI, RT, Exhibit 42 at pages 1343-1347; Exhibits Vol. VII, RT, Exhibit 45 at pages 1586-1592;

Exhibits Vol. VII, RT, Exhibit 46 at pages 1756-1758; Exhibits Vol. VI, RT, Exhibit 43 at pages 1442-1445; and Exhibits Vol. VIII, RT, Exhibit 48 at pages 1986-1988 and 1999. Also see 8 Cal. Code Regs., § 9789.10 subdivision (e).)

A certified coder is an individual that has been certified by the American Academy of Professional Coders and has proven by rigorous examination and experience that he or she knows how to read a medical chart and assign the correct CPT codes for a wide variety of clinical cases and services. Medicare's 2000 "Correct Coding Initiative" ensures that CPT coding is not biased or influenced by expected reimbursement. If an ASC operative report were to be provided to ten different certified coders, each should produce the exact same CPT codes. (Exhibits Vol. V, RT, Exhibit 39 at pages 1030-1038; Exhibits Vol. VII, RT, Exhibit 45 at pages 1585-1586, 1523-1528 and 1719-1720; Exhibits Vol. VI, RT, Exhibit 42 at pages 1325-1327; and Exhibits Vol. VIII, RT, Exhibit 48 at pages 1993-1997.)

D. Senate Bill 863 Reform

Despite the OMFS and a nationally recognized medical billing methodology, employers and medical providers still argued over what is a reasonable fee for service. Some billing disputes centered on whether the services were properly coded, while others revolved around the appropriate value for a given service. If the disputes could not be resolved in workers' compensation cases, medical providers and employers were forced to litigate the billing dispute issue before the Board, which often was ill-equipped to adjudicate them.

In 2012, the Legislature extensively reformed the workers' compensation statutes relating to medical treatment by enacting Senate Bill 863. When enacting Senate Bill 863, the Legislature reaffirmed the California Constitutional public policy "to accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character." The Legislature stated that "Existing law provides no method of medical billing dispute resolution short of litigation. Existing law does not provide for medical billing and payment experts to resolve billing disputes and billing issues are frequently submitted to workers' compensation judges without the benefit of independent and unbiased findings on these issues. Medical billing and payment systems are a field of technical and specialized expertise, requiring services that are not available through the civil service system." (Senate Bill 863, § 1, subds. (a) and (h).)

Senate Bill 863's reforms included a new means of resolving medical billing disputes by adding sections 139.5, 4603.3, 4603.6 and 4903.5 and amending sections 4603.2 and 4622. Those provisions of the act relate to a new administrative independent bill review (IBR) procedure. (Senate Bill 863, §§ 7, 36, 37, 39, 53 and 63.) "This act shall apply to all pending matters, regardless of date of injury, unless otherwise specified in this act, but shall not be a basis to rescind, alter, amend, or reopen any final award of workers' compensation benefits." (Senate Bill 863, § 84.) Senate Bill 863 does not specify that the

IBR procedure applies to anything other than "all pending matters."

Senate Bill 863 provides for a new and complete administrative procedure for prompt payment of medical treatment bills and quick resolution of billing disputes. The new IBR procedure is designed to be the last word on the reasonable amount for medical services.

The administrative director must contract with one or more independent bill review organizations to conduct reviews and resolve billing disputes. (§ 139.5.) New procedures and time limits for payment of medical treatment bills were established to ensure that disputes are resolved through the IBR program, including what documents must be submitted in support of a bill. (§ 4603.2, subd. (b) and § 4903.8, subd. (d).) Employer payment must be made within 45 days of receipt of the required documentation. (§ 4603.2, subd. (b).).[4] Upon payment, adjustment, or denial of a medical bill, the employer must provide an explanation of review (EOR). (§ 4603.3.)

If the medical provider disagrees with the amount paid by the employer, the provider must request a second review reconsideration within 90 days of service of the EOR (or a Board order resolving a threshold issue stated in the EOR). The request for second review must be supported by required documentation. The bill is deemed satisfied if the provider fails to timely request

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[4] Medical treatment providers are also required to submit detailed documentation and declarations under penalty of perjury in support of their liens filed with the Board. (8 Cal. Code Regs., §§ 10550 and 10770.)

the second review. The employer must provide a written response within 14 days of the provider's request for a second review and the employer must pay any balance determined to be due within 21 days. (§ 4603.2, subd. (e).)

"If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided in Section 4603.6. *Except as provided in paragraph (4) of subdivision (e)*, the appeals board shall have jurisdiction over disputes arising out of the subdivision pursuant to Section 5304." (§ 4603.2, subd. (e), paragraphs 4 and 5, emphasis added.)

The provider must make the request for IBR within 30 days of service of the employer's second review on a form prescribed by the administrative director supported by required documentation and payment of an administrative fee. (§ 4903.6, subds. (a) – (c).) The administrative director must assign the request to an independent bill reviewer within 30 days and notify the parties. (§ 4903.6, subd. (d).) The independent bill reviewer must make a determination within 60 days of assignment. (§ 4903.6, subd. (e).) The independent bill reviewer's determination is final and binding on all parties unless an aggrieved party files a verified appeal with the Board within 20 days of service of the determination upon limited statutory grounds. (§ 4903.6, subd. (f).) If the determination is reversed, the dispute must then be remanded back to a different independent bill reviewer for determination. (§ 4903.6, subd. (g).)

E. Elite's Evidence of Claimed Reasonableness

Elite correctly contends that: "Costs of operation of the Elite Surgery Centers are irrelevant to the reasonableness of fees…. The Board found the best and most workable method for determining reasonableness [of Elite's charges for facility fees] is to compare the charge with charges of similarly situated providers in the market place." Accordingly, Elite produced no evidence of its costs of operation or profit. (Exhibits Vol. I, Response to Request for Production of Documents, Exhibit 11, at page 76.) However, Elite produced no evidence of what any other San Diego County ASC charged or accepted for the same or similar service. Because it "inadvertently destroyed" them in 2005, Elite was unable to produce its own records of what it charged and accepted before it increased its prices in November of 2000. "In addition, the computer system that contained these records crashed and the data was unable to be retrieved." (Exhibits Vol. I, Response to Request for Production of Documents, Exhibit 11, at page 73.) When Elite "inadvertently destroyed" its records, it was subject to two WCAB subpoenas and a formal request for production of documents by some of the Petitioners and a WCAB order to show cause. (Exhibits Vol. V, RT, Exhibit 40, at pages 1149-1175.)

Elite relies only upon evidence from Rocky Gentner in an attempt to prove the reasonableness of its charges and what Petitioners should pay. (Exhibits Vol. IV, V, and IX, RT, Exhibits 38-41 and 49 at pages 855-1279 and 2063-2235.) Gentner is not an independent or unbiased witness. Gentner's background was

to help his employer and other ASCs collect their disputed bills in proceedings before the Board through training of bill collectors and providing testimony at the Board. (Exhibits Vol. IV, RT, Exhibit 38 at pages 860-861 and 927-929; Exhibits Vol. V, Exhibit 39 at pages 1066-1070 and Exhibits Vol. V, Exhibit 41 at page 1255.)

Over multiple evidentiary objections, Gentner was permitted to opine that Elite should be allowed a percentage of whatever Elite decided to charge namely (a) 57.6% of billed charges for knee procedures (which averaged $18,383.59); (b) 63.9% of billed charges for shoulder procedures (which averaged $12,303.67); and (c) 61.9% of billed charges for epidural injection procedures (which averaged $3,191,46). Gentner based his opinions on his "statistical analysis" of unauthenticated data not in evidence from Elite and fourteen ASCs located in Fresno, Kern, Santa Barbara, Ventura, Los Angeles, Riverside, and Orange Counties. Gentner undertook no analysis as to whether any of the underlying services had been correctly coded or billed. (Exhibits Vol. I, Table from Gentner file, Exhibit 9 at page 66; Exhibits Vol. I, List of surgical centers, Exhibit 10 at page 67; Exhibits Vol. IV, RT, Exhibit 38 at pages 864-869, 884-886, 911-912, 929-957 and 978-979; Exhibits Vol. V, RT, Exhibit 39 at pages 989-1062; and Exhibits Vol. V, RT, Exhibit 41 at pages 1260-1262.)

Gentner's unauthenticated data was intentionally not offered into evidence "so as not have my computer part of your discovery, I'm not going to offer that. But could I produce it?

Yes, I could produce it . . . I didn't know you – that that needed to be authenticated by an outside third party . . . I could obviously do that [produce the actual raw data information] if that was---if I'm directed to do so." (Exhibits Vol. IV, RT, Exhibit 38, at page 911; Exhibits Vol. V, RT, Exhibit 39 at pages 1050 and 1058; and Exhibits Vol. V, RT, Exhibit 41 at page 1263.)[5]

Elite's managing partner, David Kupfer, M.D., admitted that he did not consider the other ambulatory surgery centers that formed the basis of Gentner's "statistical analysis" located in counties outside of San Diego to be competitors. (Exhibits Vol. V, RT, Exhibit 40, at pages 1141-1142.) Kupfer thinks that Elite's charges are justified because the quality of care and service provided at Elite is superior to that of any hospital and Elite invested a lot of money in facilities, equipment, and personnel. (Exhibits Vol. IV, Exhibit 37 at pages 776-788; and Exhibits Vol. V, RT, Exhibit 40 at pages 1093-1110 and 1118-1119.)

F. Petitioners' Evidentiary Objections

Petitioners accused Elite with spoliation of its own billing records and repeatedly challenged the admissibility of Gentner's opinions and documents based upon his so-called "database"

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[5] Computer printouts contained in 3 large binders of material marked as trial exhibits 93-95 do not contain the actual unedited source data reviewed by Gentner. Instead they are only a presentation of selected data edited by Gentner with additional data fields created and added by Gentner. (Exhibits Vol. IV, RT, Exhibit 38 at pages 877, 911, 945-946 and 972-973; Exhibits Vol. V, RT, Exhibit 39 at pages 1049-1050 and 1057-1061; and Exhibits Vol. V, RT, Exhibit 41 at pages 1195, 1214-1217 and 1237-1263.)

because the underlying data had not been authenticated and was not in evidence. Petitioners challenged the relevance of data from ASCs located outside of the San Diego County market place. Petitioners filed pre-trial motions in limine, offered multiple evidentiary objections throughout the trial, and filed post-trial motions to strike Gentner's objectionable evidence. (Exhibits Vol. III, RT, Exhibit 35 at pages 603-612 and 615-633; Exhibits Vol. IV, RT, Exhibit 38 at pages 866-867 and 904-906; Exhibits Vol. V, RT, Exhibit 39 at pages 993-995; Exhibits Vol. V, RT, Exhibit 40 at pages 1162-1176; Exhibits Vol. V, RT, Exhibit 41 at pages 1193-1198; 1214-1222; 1269-1276 [RT 430-435; 451-459; 506-513]; Exhibits Vol. VI, RT, Exhibit 42 at pages 1380-1381; Exhibits Vol. I, Motion to Strike, Exhibit 12 at page 81; and Exhibits Vol. III, Minutes of Hearing, Exhibit 33 at pages 555-560.)

Petitioners expressly reserved and renewed their evidentiary objections in their Petition for Reconsideration. (Exhibits Vol. I, Petition for Reconsideration, Exhibit 14 at pages 157-159.) Petitioners now renew those evidentiary objections.

G. Petitioners' Evidence

Petitioners presented a comprehensive report and oral testimony from expert witness Henry Miller, Ph.D. based upon the trial exhibits in evidence. (Exhibits Vol. I, Report of Henry Miller, Ph.D., Exhibit 3 at page 6.)[6] Dr. Miller is an independent

[6] Dr. Miller's findings and conclusions are based upon testimony and exhibits that are in the evidentiary record as listed in the 5-page "Exhibit A" attached to his comprehensive report. (Exhibits Vol. I, Exhibit 3 at pages 24-29.)

and unbiased witness with national expertise with respect to ASC billing and fee schedule methodology. (Exhibits Vol. I, Resume of Henry Miller, Ph.D., Exhibit 4 at page 31; and Exhibits Vol. VIII, RT, Exhibit 48 at pages 1972-1986.) Dr. Miller concluded that (a) Elite's charges are grossly disproportionate to those of any other San Diego County provider; (b) Rocky Gentner's analysis and opinion that Elite should be paid a percentage of whatever it decided to charge is fundamentally flawed; and (c) the ASC OMFS is the only objective, quick and fair method for determining a reasonable fee for Elite's services. (Exhibits Vol. I, Report of Henry Miller, Ph.D., Exhibit 3 at page 6; and Exhibits Vol. VIII and IX, RT, Exhibit 48-49, at pages 1969-2235.)

Among other things, Dr. Miller considered what other San Diego County providers charged and accepted for similar services, including the Declarations of Arthur Casey, Susan Raub and Jill Degnan. (Exhibits Vol. I, See Declarations of Arthur Casey, Susan Raub and Jill Degnan [all without attached exhibits] Exhibits 6, 7 and 8, respectively at pages 49, 55 and 62.)

Arthur Casey has been an ASC manager for over 20 years and was responsible for managing 50 ASCs in California, Arizona, Nevada, Hawaii, and New Mexico. Casey holds a certification for expertise in the management of ASCs and has been a longtime member of the Ambulatory Surgical Center Association (ASCA) and the California Ambulatory Surgery Association (CASA), serving on its Board of Directors. Before 2004, certain "rogue facilities" charged workers' compensation

insurance companies exorbitant fees way above the average charges of other ASCs. That was the impetus for the Legislature to devise a fee schedule. Casey was involved in the development of the ASC OMFS, including testifying before the Legislature. Elite's charges were excessive and significantly higher than industry norms. By way of an example, Elite's average charge for knee procedures was three times the amount Casey was accustomed to seeing. (Exhibits Vol. I, Declaration of Arthur Casey, Exhibit 6 at page 49; and Exhibits Vol. VII, RT, Exhibit 46 at pages 1730-1746.)

Jill Degnan has been a workers' compensation claims administrator for 24 years and is the workers' compensation claims manager for the City of San Diego. The City produced every bill and payment record for facility fees for ASC services provided for injured City workers during the year 2000, including those of Elite before its fee increase in November. City of San Diego archived documents prove the usual and customary charges by multiple ASCs and what they accepted as full and final payment. This includes data from Coast Surgery Center, Frost Street Outpatient Surgical Center, Oasis HealthSouth Surgery Center, Pacific Surgical Institute of Pain Management, and Elite's Point Loma Surgical Center. After the ASC OMFS went into effect on January 1, 2004, the City of San Diego had no problem with respect to access to San Diego County ASCs to care for City employees and has negotiated contracts with several ASC facilities to accept payment *less* than the ASC OMFS.

(Exhibits Vol. I, Declaration of Jill Degnan, Exhibit 8 at pages 62; and Exhibits Vol. VI, RT, Exhibit 44 at pages 1498-1522.)

Susan Raub is a 20 year administrator for several ASC facilities and is now the administrator for San Diego Outpatient Ambulatory Surgery Center (SDOASC), located only five miles from an Elite facility. Raub presented evidence of what SDOASC usually and customarily charged and accepted for facility fees before January 1, 2004. Raub provided testimony that the ASC OMFS is reasonable compensation for services provided before January 1, 2004. "I would take it so fast, it would make your head swim. I have found the fee schedule to be more than adequate payment." (Exhibits Vol. I, Declaration of Susan Raub, Exhibit 7 at page 55; and Exhibits Vol. VII, RT, Exhibit 45 at pages 1567-1725.)

Based upon a review of all of the facts in the evidentiary record, Dr. Miller opined that Elite's charges were unreasonable because Elite's charges were: (a) more than 2 times the maximum amount allowed by law for full service inpatient hospitals in the same area, even if substantially longer stays were involved; (b) up to 7 times more than what Elite itself usually and customarily charged before it increased its charges in 2000; (c) up to 10 times more than what Elite itself usually and customarily accepted as full payment before 2000; (d) up to 4-5 times more than the fees charged by any ASC in the same geographic area; (e) up to 24 times more than the amounts accepted by other outpatient surgery centers in the same geographic area; and (f) up to 7 times more than the maximum

facility fee under the ASC OMFS for the same services provided after January 1, 2004. Dr. Miller concluded that the findings and conclusions of Elite's witness Rocky Gentner were fundamentally flawed. Elite's billing procedures do not comport with any nationally recognized standard protocol or procedure. Gentner's statistical analysis of Elite's flawed billing is therefore equally flawed. Gentner's ultimate recommendation that Elite be paid a percentage of whatever Elite arbitrarily chose to bill is therefore unreasonable and materially exceeds the facility fees charged and accepted by any other ASC in the same San Diego County geographic area. (Exhibits Vol. I, Report of Henry Miller, Ph.D., Exhibit 3 at pages 8-12; Exhibits Vol. VIII, RT, Exhibit 48 at pages 2013-2044; and Exhibits Vol. IX, RT, Exhibit 49 at pages 2076-2084 and 2218-2220.)

Dr. Miller provided evidence that application of the ASC OMFS to Elite's disputed bills produced the only nationally recognized methodology to objectively and quickly determine a reasonable facility fee consistent with the San Diego County market place. "[T]he CPT system developed by the AMA is the only system that exists for classifying procedures for payment." There is no other methodology for remuneration for facility fees for ASCs. (Exhibits Vol. VIII, RT, Exhibit 48 at pages 1986-1988, 1999-2005 and 2060-2061.)

The ASC OMFS is easily identifiable, objective, transparent, easy to calculate, and provides fair compensation, including a reasonable profit of 20%. Application of the ASC OMFS to all of Elite's unresolved bills would take about one hour

because it is an objective straightforward mathematical formula. Elite provided no other viable alternative methodology. (Exhibits Vol. I, Report of Henry Miller, Ph.D., Exhibit 3 at pages 22-23; Exhibits Vol. VIII, RT, Exhibit 48 at pages 2060-2061; and Exhibits Vol. IX, RT, Exhibit 49 at pages 2066-2069.)

H. The Board's Decision and Denial of Reconsideration

After the case was submitted, but before a decision issued, the Legislative changes enacted by Senate Bill 863 went into effect on January 1, 2013. Just one month later on February 1, 2013, the workers' compensation administrative law judge (WCALJ) determined that a reasonable facility fee for arthroscopic knee, arthroscopic shoulder, and epidural injection procedures performed in San Diego County before January 1, 2004 is $5,207.85, $4,340.95, and $2,337.52 respectively, or the amount billed, whichever is less. The WCALJ applied a Solomon-like "splitting the baby in half" approach to determine a reasonable methodology. The WCALJ relied upon the ASC OMFS and the official medical fee schedule in effect from April 13, 2001 through December 31, 2003 for full service inpatient hospital services. "The halfway point between these two schedules constitutes a reasonable facility fee" using the average maximum amount payable to the 21 San Diego County hospitals. (Exhibits Vol. I, Findings and Order, Exhibit 13, at page 95.)

Petitioners timely sought Board reconsideration, contending that Senate Bill 863 divested the Board of jurisdiction to determine Elite's billing dispute and challenged the evidentiary support for the WCALJ's three findings of fact.

Petitioners preserved and renewed objections to Elite's evidence. (Exhibits Vol. I, Petition for Reconsideration, Exhibit 14 at page 114.) Elite filed an Answer to the Petition for Reconsideration on March 12, 2013. (Exhibits Vol. I, Answer to Petition for Reconsideration, Exhibit 15 at page 192.) The WCALJ filed a Report and Recommendation that reconsideration be denied on March 18, 2013. (Exhibits Vol. I, Report and Recommendation on Reconsideration, Exhibit 16 at page 231.) On April 23, 2013, the Board granted reconsideration to study the matter. (Exhibits Vol. I, Order Granting Reconsideration, Exhibit 17 at page 250.)

On October 30, 2013, the Board issued the instant decision denying reconsideration adopting and incorporating the WCALJ's decision and report. (Exhibits Vol. I, Opinion and Order Denying Reconsideration, Exhibit 18 at page 252.)

LEGAL DISCUSSION

A. The Standard on Review

Upon judicial review, the court must consider whether the Board acted without or in excess of its powers, whether its order, decision, or award was unreasonable or unsupported by substantial evidence, and whether the findings of fact support the order, decision, or award. (§ 5952, subds. (c)-(e).)

Issues of statutory interpretation are questions of law subject to *de novo* review (*Zenith Ins. Co. v. Workers' Comp. Appeals Bd.* (2008) 159 Cal.App.4th 483, 490; *Genlyte Group v. Workers' Comp. Appeals Bd.* (2008) 158 Cal.App.4th 705, 714; *Vera v. Workers' Comp. Appeals Bd.* (2007) 154 Cal.App.4th 996,

1003; *Boehm & Associates. v. Workers' Comp. Appeals Bd.* (1999) 76 Cal.App.4th 513, 515-516.) The court's first task "is to ascertain the intent of the Legislature so as to effectuate the purpose of the law." (*Dyna-Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1386.)

The Board's findings must be supported by substantial evidence in light of the entire record. (§§ 5952, 5953; *Western Growers Ins. Co. v. Workers' Comp. Appeals Bd.* (1993) 16 Cal. App. 4th 227, 233; *LeVesque v. Workmen's Comp. App. Bd.* (1970) 1 Cal.3d 627, 637; *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274, 280-281; *Rubalcava v. Workers' Comp. Appeals Bd.* (1990) 220 Cal.App.3d 901, 908.) Substantial evidence generally means evidence that is credible, reasonable, and of solid value that a reasonable mind might accept as probative on the issues and adequate to support a conclusion. (*Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 159, 164.)

B. The Board Lacks Jurisdiction to Resolve Medical Billing Disputes

Legislative intent is generally determined from the plain or ordinary meaning of the statutory language. The statute's every word and provision should be given effect so that no part is useless, deprived of meaning, or contradictory. Interpretation of the statute should be consistent with the purpose of the statute and statutory framework. (*Marsh v. Workers' Comp. Appeals Bd.* (2005) 130 Cal.App.4th 906, 914*; DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 387-388; *Lungren v.*

Deukmejian (1988) 45 Cal.3d 727, 735; *Moyer v. Worker's Comp. Appeals Bd.* (1973) 10 Cal.3d 222, 223, 230; *Young v. Gannon* (2002) 97 Cal.App.4th 209, 223.)

When enacting Senate Bill 863's comprehensive reform of the workers' compensation system in 2012, the Legislature unambiguously articulated its intent to remove medical billing disputes from the jurisdiction of the Board for "all pending matters, regardless of date of injury, unless otherwise specified in this act." (*Valdez v. Workers' Comp. Appeals Bd.* (2013) 57 Cal.4th 1231, 1238 citing Senate Bill § 84). Senate Bill 863 mandates that the provider's exclusive remedy is through administrative IBR.

The administrative director's implementing regulations purport to limit IBR to only medical treatment rendered "on or after January 1, 2013. (8 Cal. Code Regs., § 9792.5.4 et seq.) However, regulations must be within the scope of the authority conferred by statute and reasonably necessary to effectuate the purpose of the statute. Administrative regulations which exceed the scope of the enabling statute are invalid. (*Agricultural Labor Relations Bd. v. Superior Court* (1976) 16 Cal. 3d 392, 41; *Woods v. Superior Court* (1981) 28 Cal. 3d 668, 680.) "Administrative regulations that alter or amend the statute or enlarge or impair its scope are void and courts not only may, but it is their obligation to strike down such regulations." (*Morris v. Williams* (1967) 67 Cal. 2nd 733,747.)

The administrative director's interpretation of Senate Bill 863 with respect to application of independent bill review

procedure only to dates of service after January 1, 2013 is clearly erroneous and irreconcilable with the clear Legislative intent articulated in sections 1 and 84 of Senate Bill 863. The act does not specify that IBR only applies to dates of service after January 1, 2013. To the contrary, the Legislature stated its intent that IBR is to apply to all pending matters.

The Board's decision must therefore be vacated and the matter remanded with direction that Elite's billing dispute be administratively resolved through IBR, with Elite first to seek "second review" reconsideration of its disputed bills pursuant to section 4603.2.

C. No Evidence Supports the Board's Findings of Fact

If the Board has jurisdiction to resolve Elite's consolidated medical billing dispute, the court's next inquiry is whether the Board's three findings of fact are supported by substantial evidence. Substantial evidence must be reasonable in nature, credible, and of solid value such that a reasonable mind might accept it as adequate to support a conclusion. (*Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd., supra,* 34 Cal.3d 159, 164.) In examining the entire record, the court "may not simply isolate evidence which supports or disapproves the board's conclusions and ignores other relevant facts which rebut or explain the supporting evidence ... ." (*Ibid.*) Although the court may not reweigh evidence or decide disputed facts, "this court is not bound to accept the WCAB's factual findings if determined to be unreasonable, illogical, improbable, or inequitable when viewed in light of the overall statutory scheme" (*id. at p. 233*), or

"where they do not withstand scrutiny when considered in light of the entire record ... ." (*Bracken v. Workers' Comp. Appeals Bd., supra,* 214 Cal. App. 3d 246, 254.)

In workers' compensation matters, the burden of proof rests on the party or lien claimant "holding the affirmative of the issue" by a preponderance of the evidence. Preponderance of the evidence means that evidence that, when weighed with that opposed to it, has more convincing force and the greater probability of truth." (§ 5705 and § 3202.5.) Where the injured employee does not prosecute his or her claim, the lien claimant bears the burden of establishing the injury, entitlement to benefits, and the reasonable value of the services. (*Zenith Insurance Company v. Workers' Comp. Appeals Bd.* (*Capi*) (2006) 138 Cal.App.4th 373, 376-377.)

When seeking a facility fee, Elite may sustain its burden of proof by establishing facility fees of other inpatient and outpatient providers in the geographical area in which the services were rendered. Even absent rebuttal evidence, the Board cannot find the fees charged by Elite to be "reasonable" if "grossly disproportionate" to the amount charged or accepted by other outpatient and inpatient facilities in the same geographical area for the same or similar services. *(Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 Cal. Comp. Cases 1588, 1591 [Appeals Board en banc opinion] (*Kunz)*; *Tapia v. Skill Master Staffing* (2008) 73 Cal. Comp. Cases *1338 [Appeals Board en banc opinion]*

(*Tapia*); *Torres v. AJC Sandblasting* (2012) 77 Cal. Comp. Cases 1113 [Appeals Board en banc opinion] (*Torres*).)[7]

Elite failed to sustain its burden of proving the reasonableness of its charges. The entire record proves that Elite's charges were grossly disproportionate to the amount charged or accepted by any other ASC in San Diego County for the same or similar services. Elite's charges were double the "reasonable maximum fee" for the same procedures provided by the 21 San Diego County full service hospitals. (Exhibits Vol. I, Report of Henry Miller, Exhibit 3 at pages 8-12.)

In this case, the Board determined that a reasonable facility fee for arthroscopic knee, arthroscopic shoulder, and epidural procedures to be $5,207.85, $4,340.95 and $2,337.52, respectively. On review, this court must determine whether any evidence supports the Board's three factual findings.

Elite concedes that: "The Board found the best and most workable method for determining reasonableness [of Elite's charges for facility fees] is to compare the charge with charges of similarly situated providers in the market place." (Exhibits Vol. I, Response to Request for Production of Documents, Exhibit 11, at page 76, citing *Kunz, supra*.) By Elite's own admission, the relevant evidence is limited to what Elite's "similarly situated"

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[7] En banc decisions of the Board (§ 115) are binding precedent on all Board panels and workers' compensation judges. (8 Cal. Code Regs., § 10341; *Signature Fruit Co. v. Workers' Comp. Appeals Bd.* (*Ochoa*) (2006) 142 Cal.App.4th 790, 796, fn. 2; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6.)

competitor ASCs in San Diego County "market place" charged and accepted for the same services.

There is no evidence to support the WCALJ's three findings of fact. The record is devoid of evidence that even one other San Diego County ASCs charged or accepted an amount even close to what the WCALJ determined to be a reasonable facility fee. To the contrary, all of the evidence from the San Diego County market place proves that Elite's competitor ASC facilities usually and customarily charged and accepted far *less* than the amounts the WCALJ determined to be a reasonable facility fee in his three findings of fact.

For example, Table 6 of Dr. Miller's report calculates what Elite's competitors in the San Diego County market place charged and accepted based on the billing and payment data found in the City of San Diego archives. This evidence shows:

WCALJ Findings of Fact vs. City of San Diego ASC Data[8]

	City of San Diego Claims Data		
	Average Charge	**Average Paid**	**WCALJ's Findings of Fact**
CPT 29826 Shoulder Arthroscopy	$ 2,126	$ 1,052	$ 4,340.95
CPT 29880 Knee Arthroscopy	2,610	1,271	5,207.85
CPT 29881 Knee Arthroscopy	2,456	1,370	5,207.85

[8] (Exhibits Vol. I, Findings and Order, Exhibit 13 at page 95; Exhibits Vol. I, City of San Diego ASC billing and payment data from Henry Miller report, Table 6, Exhibit 3 at page 14.)

	City of San Diego Claims Data		
	Average Charge	Average Paid	WCALJ's Findings of Fact
CPT 62289 Injection into Spinal Canal	1,645	961	2,337.52
CPT 62290 Injection for Spine Disk X-Ray	1,270	775	2,337.52
CPT 62298 Cervical or Thoracic Injection	1,403	1,403	2,337.52
CPT 64442 Facet and/or Perifacet Joint Injection	955	265	2,337.52

There is no evidence to support the WCALJ's unique methodology of "splitting the difference" between the ASC OMFS and the maximum allowable amount payable for inpatient services at any of the 21 San Diego County full service hospitals. Hospital data has no relevance when determining a reasonable fee payable to an ASC. There is no evidence that any San Diego County ASC (other than Elite) charged anything close to that charged by a San Diego County full service hospital. Hospital data therefore does not establish the upper limit of the "range of the evidence" as suggested by the Board.

Although not their burden to do so, Petitioners proved through Dr. Miller that the ASC OMFS maximum allowable facility fee for the same services rendered by Elite (or any other San Diego County ASC) on or after January 1, 2014 provides the only appropriate methodology for resolving the Elite billing dispute "expeditiously, inexpensively, and without incumbrance of any character." The ASC OMFS offers a reliable, consistent and appropriate billing system based upon the information

provided by the certified coders. Susan Raub testified that as the administrator of San Diego Outpatient Ambulatory Surgical Center located just 5 miles from an Elite facility, she would accept the ASC OMFS as reasonable payment for services provided before January 1, 2004. "I have found the [ASC OMFS] fee schedule to be more than adequate payment." (Exhibits Vol. I, Declaration of Susan Raub, Exhibit 7 at pages 55; Exhibits Vol. VII, RT, Exhibit 45 at pages 1567-1725.) Elite presented no rebuttal evidence from even one other San Diego County ASC.

The WCALJ's three findings of fact are not supported by substantial evidence and must therefore be vacated.

CONCLUSION

Because of Senate Bill 863, the Board no longer has jurisdiction to determine Elite's consolidated medical billing dispute. Elite must instead pursue its new exclusive administrative remedy as provided by Senate Bill 863. Elite must first submit its bills for a "second review" pursuant to section 4603.2. If that does not resolve Elite's billing dispute, Elite must then apply for administrative independent bill review pursuant to section 4903.6.

Even if the Board does have jurisdiction to resolve Elite's billing dispute, there is no evidence to support the Board's three findings of fact as to what constitutes a reasonable facility fee within the San Diego County market place. Instead, the evidence proves that the ASC OMFS provides the only appropriate methodology for resolving Elite's billing dispute "expeditiously,

inexpensively, and without incumbrance of any character" consistent with the declared public policy of the State and the Legislature's unambiguous intent.

This petition should therefore be granted. The respondent Board should be directed to certify and return a full and correct copy of the records and documents reviewed by the Board on the Petition for Reconsideration so that the same may be reviewed by this court.

Respectfully submitted,

December 10, 2013

HEGGENESS, SWEET, SIMINGTON & PATRICO, A P.C.

By: _____
Clifford D. Sweet, III
Attorneys for Defendants and Petitioners
CALIFORNIA INSURANCE GUARANTEE ASSOCIATION; AIU INSURANCE COMPANY; AMERICAN HOME ASSURANCE COMPANY; INSURANCE COMPANY OF THE WEST; EXPLORER INSURANCE COMPANY; SOLAR TURBINES, INC.; BAE SYSTEMS SHIP REPAIR, INC. and ACE AMERICAN INSURANCE COMPANY

CERTIFICATE OF WORD COUNT

(Cal. Rules of Court, rule 8.504(d)(1).)

The text of this petition consists of 6,824 words [8,400 is word limit] as counted by the Microsoft Word version 2007 word processing program used to generate the petition.

Dated: December 10, 2013

Clifford D. Sweet, III

VERIFICATION

I, Clifford D. Sweet, III, declare:

I am an Attorney at Law fully admitted to practice before all courts of the State of California, and am a member of Heggeness, Sweet, Simington & Patrico, a Professional Corporation, which has its professional offices at 4180 Ruffin Road, Suite 275, San Diego, CA 92123-1834. Heggeness, Sweet, Simington & Patrico, A P.C., are the attorneys of record for each of the Petitioners, and as such, I am authorized to make and do make this declaration on behalf of each of the Petitioners. I have read the foregoing Petition for Writ of Review and I am informed and believe the matters therein to be true and correct, and on that ground allege that the matters stated therein are true and correct. As attorney for Petitioners, I am more familiar with the matters stated in the foregoing than are the officers of Petitioners and therefore make this verification on behalf of Petitioners pursuant to California Code of Civil Procedure Section 446.

I declare under penalty of perjury that the above is true and correct and was executed by me on this 10th day of December 2013 at San Diego, California.

_____

Clifford D. Sweet, III

PROOF OF SERVICE

(Cal. Rules of Court, rule 8.495(a)(3).)

I declare under penalty of perjury as follows:

I am employed in the County of San Diego, State of California. I am over the age of 18 and not a party to the within action. My business address is: Law Offices of Heggeness, Sweet, Simington & Patrico, A P.C., 4180 Ruffin Road, Suite 275, San Diego, CA 92123-1834. On December 12, 2013, I served the foregoing Petition for Writ of Review by placing a true and correct copy of the document in an envelope addressed to:

Rick Dietrich, Esq., Secretary Workers' Compensation Appeals Board P.O. Box 429459 San Francisco, CA 94142-9459 (2 copies)	Respondent
Anthony J. Dain, Esq. Procupio, Cory, Hargreaves & Savitch 525 B Street, Suite 2200 San Diego, CA 92101	Attorneys for Real Parties in Interest Elite Surgical Centers, Escondido, L.P., Elite Surgical Centers, Del Mar, L.P. and Point Loma Surgical Center, L.P.

I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. Postal Service on that same day with postage thereon fully prepaid at San Diego, California in the

ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that the same was executed by me at San Diego, California on December 12, 2013.

Tasha Forbes