WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

BERNADETTE LUNCINSKI, *Applicant*

vs.

BACKWOODS INN;
NATIONAL LIABILITY & FIRE INSURANCE, administered by ACCA, *Defendants*

Adjudication Numbers: ADJ4383952 (VNO0542062)
ADJ4362592 (VNO0542063), ADJ6871086
Van Nuys District Office

OPINION AND DECISION AFTER RECONSIDERATION

We granted reconsideration to further study the factual and legal issues in this case. This is our Opinion and Decision after Reconsideration.

National Liability & Fire Insurance, administered by ACCA (a division of Berkshire Hathaway Homestate Companies) (collectively defendant), seeks reconsideration of the Joint Findings and Order issued by the workers' compensation administrative law judge (WCJ) on November 15, 2019. As relevant herein, the WCJ found that the services of lien claimants [Edwin Haronian, M.D. and Osteon Surgery Center (Osteon)] were authorized and/or certified by the claims administrator as found in Exhibits 1 through 12; that medical treatment was reasonable and necessary based on Agreed Medical Evaluator (AME) Dr. Gerald Paul's report on March 10, 2009; that Exhibits 101 through 146 are lien claimant's payment dispute appeals, second requests, or second appeal requests, to which defendant failed to submit any evidence in response; that defendant is to pay the amounts billed by the provider pursuant to Administrative Director (AD) Rule 9792.5.5; and that any other billing by the provider, including Osteon, is reasonable and necessary regarding the cervical and lumbar spine treatment pursuant to Dr. Paul's March 10, 2009 report.

Defendant contends that lien claimants failed to satisfy their burden of proof to warrant payment of any amount. Defendant argues that lien claimants did not demonstrate the reasonableness and necessity of the treatments by demonstrating that the treatments were

consistent with the Medical Treatment Utilization Schedule (MTUS) or by rebutting the MTUS with scientific evidence; that Osteon failed to demonstrate that applicant's carpel tunnel syndrome was industrially related; and that Dr. Haronian treated body parts that were not industrially related, such as applicant's wrists or knees.

Lien claimants did not file an answer. The WCJ issued a Report and Recommendation on Petition for Reconsideration (Report) recommending that we deny reconsideration.

We have considered the allegations of the Petition for Reconsideration and the contents of the Report of the WCJ with respect thereto. Based on our review of the record, and for the reasons discussed below, we will rescind the Joint Findings and Order and return the matter to the WCJ for further proceedings consistent with this decision. When the WCJ issues a new decision, any aggrieved party may timely seek reconsideration.

FACTUAL BACKGROUND

Applicant, while employed on August 26, 2006, by defendant, claims to have sustained injury arising out of and in the course of employment (AOE/COE) to her cervical and lumbar spine (ADJ4383952); while employed during the period of August 26, 2005, through August 26, 2006, by defendant, claims to have sustained injury AOE/COE to her cervical spine (ADJ4362592); and while employed during the period of August 26, 2006, through January 27, 2007, by defendant, claims to have sustained injury AOE/COE to her cervical and lumbar spine (ADJ6871086). (Minutes of Hearing (MOH), September 19, 2019, pp. 2:12-13; 3:3-5; 3:19-21.)

Lien claimants are seeking reimbursement for their medical treatment services. Osteon provided medical services on September 14, 2012, in connection with applicant's left wrist surgery. In an itemized bill, Osteon charged $18,073.35, of which defendant paid $5,669.41 leaving a balance of $12,403.94. (Ex. 147, Osteon Surgery Center Itemized Billing, July 19, 2017.) Dr. Haronian provided medical services from April 10, 2007, to April 12, 2016, for a total of $133,790.73. Of this amount, it appears that defendant paid $42,715.69 with an outstanding balance of $83,627.34. Dr. Haronian submitted only two invoices for all of his services: the first invoice appears to covers a period of treatment from 2007 to 2008, and the second invoice appears to covers a period from 2008 to 2016. (Ex. 13, Billing from Edwin Haronian, July 19, 2017.)[1]

[1] According to defendant's Petition, Dr. Haronian provided approximately 81 dates of service over the course of 10 years.

AME Dr. Paul issued three medical reports in 2008 and two in 2009. (Exhibits A-E, Medical Reports, February 22, 2008, June 9, 2008, November 13, 2008, March 10, 2009, August 7, 2009.) In the March 10, 2009 report, applicant complained of pain in her neck, low back, and right arm. (Ex. D, Medical Report, March 10, 2009, p. 3.) There are no complaints associated with the left upper extremity or wrist; in fact, applicant reported that she did not have any difficulty writing or typing. (*Id.* at p. 2.)

On September 14, 2012, Dr. Edwin Haronian operated on applicant's left wrist at Osteon. (Ex. 148, Operative Report, September 14, 2012.)

Dr. Haronian submitted twelve notices of authorization from defendant from 2008 to 2016. Defendant authorized prescriptions as well as various treatments for the lumbar spine, bilateral knees, and upper extremities including the left upper extremity. (Exs. 1-12, Notices of Authorizations, Various dates.)

Based on the descriptions of the exhibits in the MOH, from 2008 to 2017 Dr. Haronian issued follow-up reports, PR-2 reports, prescriptions, and/or a supplemental medical-legal reports. (Exs. 15-85, Medical Records, 2008-2017.) In 2008 and 2012 to 2015, Dr. Haronian requested numerous authorizations for various medical procedures. (Exs. 86-99, Authorization Requests, 2008, 2012-2015.) From 2012 to 2014, Dr. Haronian issued a "payment dispute" or "payment dispute, second appeal" disputing defendant's payments of his invoices. (Exs. 101-130, Payment Dispute Appeal, 2012 to 2014.) From 2014 to 2016, Dr. Haronian issued requests for second bill review. (Exs. 131-146, Requests for Second Bill Review, 2014 to 2016.) (MOH, *supra*, at pp. 4:18-22:11.)

On July 19, 2017, Dr. Haronian issued a demand letter for the balance due on his invoices. Dr. Haronian attached the two invoices, discussed above, with his demand letter. (Ex. 13, *supra*.)

Also on July 19, 2017, Osteon issued a demand letter for the balance due on its invoice. Osteon included the itemized billing, discussed above, with the demand letter. (Ex. 147, *supra*.)

On December 9, 2017, defendant issued an explanation of review (EOR) in response to Dr. Haronian's and Osteon's itemized billings that were included with their respective demand letters. (Exhibits 14 & 149, EORs, December 9, 2017.)

On July 10, 2018, defendant printed out a "Payment Detail Less Expense" sheet, which appears to document defendant's payments in applicant's workers' compensation claims. The first

check to Dr. Haronian is dated May 14, 2007, and the last check was sent on May 4, 2016. (Ex. J, Payment Detail Less Expense, July 10, 2018.)

At the lien trial on September 19, 2019, the WCJ consolidated applicant's three workers' compensation claims. (Order of Consolidation, September 19, 2019, p. 2:1-6.) As relevant herein, the issues before the WCJ were Dr. Haronian's and Osteon's liens; the reasonableness and necessity of the medical services provided; and the official medical fee schedule (OMFS). (*Id*. at p. 2:18-21.) According to the MOH, lien claimant submitted 149 exhibits as evidence; and defendant submitted Exhibits A through L. The WCJ admitted all of lien claimants' exhibits and all but one of defendant's exhibits into evidence.[2]

DISCUSSION

Reasonableness and Necessity of Medical Treatment

Decisions by the Appeals Board must be supported by substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd*. (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd*. (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd*. (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) Substantial evidence "means evidence which, if true, has probative force on the issues. It is more than a mere scintilla, and means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." (*Braewood v. Workers' Comp. Appeals Bd*. (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566] (italics and quotation marks omitted).)

When a lien claimant 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 must prove by a preponderance of the evidence all of the elements necessary to the establishment of its lien. (*Kunz v. Patterson Floor Company, Inc.* (2002) 67 Cal.Comp.Cases 1588 (Appeals Bd. en banc); *Tapia v. Skill Master Staffing* (2008) 73 Cal.Comp.Cases 1338 (Appeals Bd. en banc); *Torres v. AJC Sandblasting* (2012) 77 Cal.Comp.Cases 1113 (Appeals Bd. en banc).) Lien claimants bear the burden of proof to establish their liens in this case. (*Id*.)

Here, Dr. Haronian's and Osteon's liens are "medical treatment liens." Labor Code section 4600(a) requires the employer to provide medical treatment and services to an industrially related injured employee: "Medical, surgical, chiropractic, acupuncture, and hospital treatment, including

[2] The WCJ struck defendant's Exhibit F from the record. (MOH, *supra*, at p. 21:22-23.)

nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer." (Lab. Code, § 4600(a).) [3] Subsection (b) of section 4600 defines "medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27."[4] (Lab. Code, § 4600(b).)

Section 5307.27 authorizes the Administrative Director (AD) to adopt a medical treatment utilization schedule (MTUS). (Lab. Code, § 5307.27.)[5] The MTUS incorporates evidence-based medicine to ensure that clinical decision-making is guided by the integration of the best available research evidence with clinical expertise and patient values.[6] (Cal. Code Regs., tit. 8, §§ 9792.20(d) and 9792.21(b).) The MTUS guidelines are the standard for the provision of medical care under section 4600, and the guidelines provided in the MTUS are "presumptively correct." This presumption may be rebutted by "a preponderance of scientific medical evidence establishing that a variance from the MTUS is reasonably required to cure or relieve the injured worker from the effects of his or her injury." (Lab. Code, § 4604.5(a).)[7] To provide medical treatment not provided in the MTUS, a treating physician "bears the burden of rebutting the MTUS' presumption of correctness by a preponderance of scientific medical evidence."[8] (Cal. Code Regs., tit. 8,

[3] All further statutory references are to the Labor Code unless otherwise stated.

[4] We note that in 2008, former section 4600(b) included the following language in the definition of medical treatment: "or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines." (Former § 4600(b), Stats. 2006, ch. 819, § 2.) Stats. 2012, ch. 363, § 35 (Senate Bill (SB) 863) amended section 4600(b) to its current version.

[5] Section 5307.27 was added in 2003 by Stats. 2003, ch. 639, § 41 (SB 228).

[6] The MTUS was adopted in 2007 and has since been updated. (Cal. Code Regs., tit. 8, §§9792.20-9792.26.) The MTUS Drug Formulary, AD Rule §§9792.27.1-9792.27.23, became operative on January 1, 2018, pursuant to Government Code section 11343.45(b)(3). (Register 2017, No. 49.)

[7] The Legislature added section 4604.5 with SB 228 (Stats. 2003, ch. 639, § 27), which, as relevant herein, stated: "(a) Upon adoption by the [AD] of a medical treatment utilization schedule pursuant to Section 5307.27, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury." The current version of section 4604.5 was amended by Stats. 2012, ch. 363, § 41 (SB 863), and the subsequent amendments are not materially relevant to this case.

[8] We note that the AD has adopted various guidelines from the American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines into the MTUS at various points in time. As potentially relevant herein, AD Rule 9792.23.4 "Hand, Wrist, and Forearm Disorder Guideline," Rule 9792.23.1 "Cervical and Thoracic Spine Disorders Guidelines," and Rule 9792.23.5 "Low Back Disorders Guideline," became operative on July 18, 2009. (Register 2009, No. 25.)

§ 9792.21(d)(2).)

Here, lien claimants bear the burden of proof to establish that the medical treatment they provided was reasonable and necessary to cure applicant from the effects of her industrial injury. (*State Comp. Ins. Fund v. Workers' Comp. Appeals Bd*. (*Sandhagen*) (2008) 44 Cal.4th 230, 237-238 [73 Cal.Comp.Cases 981]; *Tito Torres v. AJC Sandblasing* (2012) 77 Cal.Comp.Cases 1113, 1121 [2012 Cal. Wrk. Comp. LEXIS 160] (Appeals Board en Banc).) To determine whether lien claimants have satisfied their burden of proof, the parties, first, need to ascertain whether there were MTUS guidelines, which covered their medical services at the time their services were provided.

In this case, it appears that Dr. Haronian is seeking reimbursement for medical services from 2007 to 2016; and Osteon is seeking reimbursement for applicant's surgery on September 14, 2012. In regards to Osteon's lien, it appears that AD Rule 9792.23.4 was operative at the time of lien claimant's wrist surgery in 2012. Thus, in order for Osteon's medical treatment to be reasonable and necessary, Osteon must demonstrate that the wrist surgery was consistent with the MTUS, or rebut the MTUS by a preponderance of the evidence. (See Lab. Code, § 4604.5(a).) This reasonableness and necessity analysis also applies to any of Dr. Haronian's medical services, which were covered by a MTUS guideline at the time of the medical services.

For any of Dr. Haronian's medical services that were provided before the adoption of a corresponding guideline in the MTUS or not covered by the MTUS, then Dr. Haronian must provide substantial evidence that the medical treatment he rendered was reasonable and necessary to cure or relieve the effects of applicant's industrial injury.

Here, the WCJ found that Dr. Paul's March 10, 2009 Report satisfied lien claimants' burden of proof that their medical treatments were reasonable and necessary. Based on the record before us, it is not entirely clear if this report satisfies either lien claimant's burden of proof. A review of Dr. Paul's March 10, 2009 Report reveals no mention of the MTUS, and Dr. Paul did not present "a preponderance of scientific evidence" to justify a variance from treatment per the MTUS. Additionally, Dr. Paul did not review any medical records for his March 10, 2009 report, and he did not discuss any of applicant's prior medical treatment. Thus, it is unclear how Dr. Paul's March 10, 2009 report could be used to evaluate or justify applicant's medical treatment prior to March 10, 2009, as reasonable and necessary. Furthermore, it is unclear how Dr. Paul's report of March 10, 2009, may be the basis for the reasonableness and necessity of medical treatment

rendered seven years later in 2016, for example. Upon return to the trial level, the WCJ should hold a hearing and give lien claimants an opportunity to explain how the evidence supports the reasonableness and necessity of their medical services, and give defendant an opportunity to explain how the evidence does not. This responsibility does not fall on the WCAB's shoulders.[9]

Defendant argues in its Petition that Osteon failed to prove that its medical services were for work-related injuries. The WCJ found that Osteon's billing was reasonable and necessary based on Dr. Paul's March 10, 2009 Report on page 8. (Finding 7, Joint Findings and Order, November 15, 2019.) In Dr. Paul's March 10, 2009 Report, applicant did not mention any subjective pain to her left wrist, and Dr. Paul did not diagnose an injury to the left wrist. Thus, it appears that Dr. Paul's March 10, 2009 Report may not be substantial evidence to support a finding that Osteon's services were for a work-related injury. On return to the trial level, we recommend that the parties comb through the evidence and address this issue.

Reasonableness of Medical Expense Costs

Prior to 2013, section 4603.2, as relevant herein, provided:

> (b)(2) Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service. Payments shall be made by the employer within 45 working days after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the itemization is contested, denied, or considered incomplete, within 30 working days after receipt of the itemization by the employer. A notice that an itemization is incomplete shall state all additional information required to make a decision. . . .
>
> (Stats. 2006, ch. 69, § 24 (AB 1806).)

Effective January 1, 2013, the Legislature amended section 4603.2 with SB 863, which added independent bill review (IBR) found in subsection (e):

> (1) If the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review

[9] We note that the WCJ admitted as evidence Dr. Paul's medical reports dated February 22, 2008, June 9, 2008, November 13, 2008, and August 7, 2009. (Exs. A-C, E.) Upon return to the trial level, we recommend that the WCJ and the parties, if necessary, address these reports in the first instance.

> pursuant to paragraph (5) of subdivision (a) of Section 4603.3. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director . . . .
>
> (2) If the only dispute is the amount of payment and the provider does not request a second review within 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.
>
> (3) Within 14 days of a request for second review, the employer shall respond with a final written determination on each of the items or amounts in dispute. Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review. This time may be extended by mutual written agreement.
>
> (4) If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6.
>
> (Stats. 2012, ch. 363, § 36 (SB 863).)

SB 863 made a substantial number of changes to workers' compensation law, one of which was the creation of the IBR process. The IBR process allowed the parties to resolve their billing disputes administratively. (*California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd*. (2014) 232 Cal.App.4th 543, 554 [79 Cal.Comp.Cases 1481].)

Lastly, AD Rule 9792.5.5 provides the process, by which the parties must follow in order to adjudicate their disputes through IBR. We note, in particular, that subsection (a) states that the provider may request a second review of the bill for "medical treatment services or goods rendered on or after January 1, 2013." Subsection (b) requires the provider to submit the request for second review within 90 days, as relevant herein, of date of service of defendant's explanation of review (EOR). (Cal. Code Regs., tit. 8, § 9792.5.5(a) & (b).)

As it relates to Dr. Haronian's medical services subject to IBR, our analysis begins with the invoice, billing, or "itemization of medical services." Pursuant to section 4603.2, the employer essentially has two paths it can take once it receives the provider's invoice: the employer can pay the invoice in full within 45 days; or the employer can contest, deny, or consider incomplete all or a portion of the invoice. If the employer considers incomplete, contests, or denies the invoice or a portion thereof, the employer must notify the provider within 30 days in an EOR pursuant to section 4603.3. If the provider disputes the amount paid by the employer, the provider must request a second review within 90 days of the EOR. Within 14 days of a request for second review, the employer must respond with a final written determination. If the provider still contests the amount

paid, the provider must request IBR pursuant to section 4603.6. (Lab. Code, § 4063.2(b)(2), (e)(1)-(4); Cal. Code Regs., tit. 8, § 9792.5.5.)

We have three issues with Finding of Fact 6: "Lien claimant's Exhibit 101 through 146 are payment dispute appeal/second review requests or second appeal requests. Defendant has failed to put into evidence any response to these requests. As such, those payments are to be paid for the amounts billed by the provider pursuant to 8 CCR 9792.5.5, to be adjusted by the parties, less payments previously paid on account thereon." This finding treats the medical treatments as if they are subject to IBR. Thus, the medical treatments must have been provided on or after January 1, 2013.

First, we note that Exhibits 101, 102, and 126-130 are payment dispute appeals for services rendered in 2012: on October 25, 2012, December 20, 2012; September 14, 2012, June 15, 2012, and July 13, 2012. (Exs. 101-102, 126-130, Payment Dispute - Appeal, January 29, 2013, February 21, 2013, January 4, 2013, September 21, 2012, October 10, 2012, November 12, 2012, and November 19, 2012.) These medical services are not subject to IBR as they were provided prior to January 1, 2013. Thus, the WCJ's finding that payment should be made in accordance to AD Rule 9792.5.5 cannot apply to these pre-2013 medical services.

Second, the WCJ found that "Defendant has failed to put into evidence any response to these requests."[10] To reach this conclusion that defendant failed to respond to Dr. Haronian's requests for second review, there first must be evidence of when the invoices were served, when defendant served its EORs in response to the invoices, and when Dr. Haronian served the requests for second bill review. Additionally, there must be evidence that Dr. Haronian and defendant timely filed their objections or responses pursuant to the provisions in section 4603.2 and AD Rule 9792.5.5. The record, unfortunately, is woefully missing many of these crucial documents.

Due to the failure of both parties to develop the record sufficiently on the IBR issue, we recommend that the WCJ hold a hearing and allow both parties to submit the evidence discussed above. Furthermore, the burden is on the parties to explain their legal arguments and positions and to cite to specific evidence that supports each argument. It is not the job of the WCJ or the Appeals Board to decipher the import, meaning, or significance of the over 160 exhibits in the record and to ascertain how the exhibits are connected to their legal arguments.

[10] It appears that the WCJ is referring to defendant's failure to submit a final written determination pursuant to section 4603.2(e)(3).

Lastly, even assuming that lien claimants are entitled to reimbursement for their medical services, the WCJ's finding that the "payments are to be paid for the amounts billed by the provider" appears inconsistent with the statutes and regulations. The OMFS establishes the reasonable maximum fees for medical services. (Lab. Code, § 5307.1.) For physician services between 2004 and 2014, AD Rule 9789.11 is applicable (Cal. Code Regs., tit. 8, § 9789.11); and for physician services rendered on or after January 1, 2014, AD Rules 9789.12.1-9789.19 are applicable. (Cal. Code Regs., tit. 8, § 9789.12.1-9789.19.) Pursuant to *Kunz*, the OMFS generally does not apply to outpatient surgical facility fees, and a lien claimant has the burden to prove the reasonableness of its facility fees based on various factors.[11] (*Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 Cal.Comp.Cases 1588, 1590 (Appeals Board en banc); *Tapia v. Skill Master Staffing* (2008) 73 Cal.Comp.Cases 1338, 1342-1343 (Appeals Board en banc).)

As for lien claimants' medical services not subject to IBR, lien claimants have the burden of proof of the reasonableness of their medical billing costs. Former section 4603.2, amended by Stats. 2006, ch. 69, § 24 (Assembly Bill 1806), and AD Rule 9792.5 provide the framework for pre-2013 medical treatment. Ultimately, the WCJ must make a determination based on substantial evidence in the record.

Accordingly, we rescind the Joint Findings and Order and return this matter to the trial level for further proceedings consistent with this decision. When the WCJ issues a new decision, any aggrieved party may timely seek reconsideration.

[11] We are not indicating that *Kunz* and *Tapia* are applicable to Osteon's lien. We simply highlight these two cases in the event our holdings in *Kunz* and *Tapia* are relevant to the facts of this case.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the November 15, 2019 Joint Findings and Order is **RESCINDED** and that the matter is **RETURNED** to the trial level for further proceedings and decision by the WCJ.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE A. ZALEWSKI, CHAIR

I CONCUR,

/s/ JOSÉ H. RAZO, COMMISSIONER

s/ KATHERINE WILLIAMS DODD, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

April 9, 2021

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

BERNADETTE LUNCINSKI
AMERICAN COMMERCIAL
BRADFORD & BARTHEL
EDWIN HARONIAN, M.D.
OSTEON SURGERY CENTER

SS/abs

I certify that I affixed the official seal of the Workers' Compensation Appeals Board to this original decision on this date. *abs*