WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

MYRA RYAN, *Applicant*

vs.

CARLSON, MESSER & TURNER, LLP; LUMBERMENS MUTUAL, in liquidation, administered by TRISTAR on behalf of CALIFORNIA INSURANCE GUARANTEE ASSOCIATION, *Defendants*

Adjudication Number: ADJ1977669 (LAO 0802562)
Los Angeles District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION AND DENYING PETITION FOR REMOVAL

We have considered the allegations of the Petition for Reconsideration or Removal and the contents of the report of the workers' compensation administrative law judge (WCJ) with respect thereto.[1] Based on our review of the record, and to the extent the petition challenges the WCJ's decision on the issue of penalties and interest, we will deny reconsideration for the reasons stated in the WCJ's report, which we adopt and incorporate. To the extent the petition challenges the reservation of jurisdiction over the issue of medical-legal charges, we deny removal based upon the WCJ's analysis of the merits of petitioner's arguments in the WCJ's report. Removal is an extraordinary remedy rarely exercised by the Appeals Board. (*Cortez v. Workers' Comp. Appeals Bd.* (2006) 136 Cal.App.4th 596, 599, fn. 5 [71 Cal.Comp.Cases 155]; *Kleemann v. Workers' Comp. Appeals Bd.* (2005) 127 Cal.App.4th 274, 280, fn. 2 [70 Cal.Comp.Cases 133].) The Appeals Board will grant removal only if the petitioner shows that substantial prejudice or irreparable harm will result if removal is not granted. (Cal. Code Regs., tit. 8, § 10955(a); see also

[1] Commissioner Lowe, who was on the panel that issued a prior decision in this matter, no longer serves on the Appeals Board. Another panelist was appointed in her place.

Cortez, supra; *Kleemann, supra*.) Also, the petitioner must demonstrate that reconsideration will not be an adequate remedy if a final decision adverse to the petitioner ultimately issues. (Cal. Code Regs., tit. 8, § 10955(a).)

For the foregoing reasons,

IT IS ORDERED that the Petition for Reconsideration or Removal is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSÉ H. RAZO, COMMISSIONER

I CONCUR,

/s/ JOSEPH V. CAPURRO, COMMISSIONER

KATHERINE A. ZALEWSKI, CHAIR
CONCURRING NOT SIGNING

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

July 24, 2023

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

LEGAL SERVICE BUREAU
LAUGHLIN, FALBO, LEVY & MORESI LLP

PAG/*ara*

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

REPORT AND RECOMMENDATION ON PETITION FOR RECONSIDERATION and REMOVAL

I
INTRODUCTION

Myra Ryan, a 38-year-old legal secretary for Carlson, Messer &Turner, filed an Application for Adjudication on 11/26/01 alleging that she sustained injury arising out of and occurring in the course of employment to her back, head, upper extremities, lower extremities, psyche, internal system, gastrointestinal system, and the condition of fibromyalgia. The claim was accepted by the employer.

Lien Claimant David Silver has filed a timely, verified Petition for Reconsideration or (sic) Removal[1] of the Findings and Orders dated 5/8/23 alleging no statutory grounds for reconsideration but the following grounds normally alleged for removal:

1. The order, decision, or action will result in significant prejudice, and;

2. The order, decision, or action will result in irreparable harm, and;

3. Reconsideration will not be an adequate remedy after the issuance of a final order, decision, or award.

Petitioner contends that the Court erred in:

1. Determining that Defendant is not liable for penalty and interest, and;

2. Reserving jurisdiction over Lien Claimant's medical-legal charges.

II
FACTS

Petitioner provided medical treatment services to Applicant for her industrial injury during the period commencing 8/26/03 through 10/6/11 (LC exhibits 13-15). The services in question only consisted of treatment examinations and reports (LC exhibits 13 and 15). Petitioner also billed Defendant for five medical-legal exams and reports.

The lien has been the subject of extensive prior litigation. The first trial involved a determination, that a prior judicial order to pay Lien Claimant was not valid or binding, and denied sanctions against Defendant. The second trial, which was on the merits of the lien, took place on 3/1/19. Petitioner did not raise the issue of entitlement to medical-legal charges. The Court took Petitioner's bills and ledgers, as well as multiple medical reports from Dr. Silver (Lien Claimant's exhibits 4-14) into evidence. The bills included proofs of service that reflected service on Kemper

[1] Since the Petition addresses a final order and an interlocutory order, it is being treated as a Petition for Reconsideration and Removal.

Insurance, but did not reflect service of any corresponding reports. The medical reports in evidence do not include proofs of service. In regards to that trial, it was determined that Petitioner was not entitled to payment over and above levels proscribed by the Official Medical Fee Schedule (OMFS). The parties were ordered to attempt to agree on an Independent Bill Reviewer, and all issues, including penalty and interest were deferred.

The Court appointed Alex Kauffman as an Independent Bill Reviewer on 10/2/21. Following his bill review (Joint exhibit Y) and deposition (Joint exhibit Z), the matter was once again submitted for decision on 11/14/22. The Court issued a Findings and Order on 1/3/23 wherein Petitioner was awarded reimbursement of its medical treatment charges in the sum of $6,779.85 based on the bill review, but nothing for its medical-legal charges since those were not raised as an issue. Additionally, penalty and interest were denied because Petitioner did not establish that the bills were served on Kemper Insurance, who was the underlying carrier prior to liquation.

Petitioner filed a Petition for Reconsideration of the 1/3/23 order alleging that the bills were served on Lumberman's Insurance which operated under the trade name "Kemper Insurance." The Court rescinded the Findings and Order of 1/3/23, and after further discussion with the parties, the matter was again submitted for decision on 4/11/23 with the understanding that Lumberman's Insurance and Kemper Insurance were synonymous for purposes of this litigation.

The Court issued a new Findings and Orders on 5/10/23 wherein Petitioner was again awarded $6,779.85 reimbursement of its medical treatment charges, but instead of disallowing the medical-legal portion of the bill, the Court reserved jurisdiction over the charges. Additionally, penalties and interest were not awarded because Petitioner did not establish service of the medical reports corresponding to the medical treatment exams at issue.

III
DISCUSSION

PENALTY AND INTEREST

Labor Code section 4603.2(b)(2) states:

> "Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or prescribed 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 with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate itemization of medical services provided, **together with any required reports** (emphasis added) 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 the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer. An explanation of review that states an itemization is incomplete shall also state all additional information required

> to make a decision. **A properly documented** (emphasis added) list of services provided and not paid at the rates then in effect under Section 5307.1 within the 45-day period shall be paid at the rates then in effect and increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization, unless the employer does both of the following:
>
> (A) Pays the provider at the rates in effect within the 45-day period.
>
> (B) Advises, in an explanation of review pursuant to Section 4603.3, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if the physician or provider disagrees. In the case of an itemization that includes services provided by a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the itemization shall satisfy the requirements of this paragraph."

In this case, all of Petitioner's charges were for office visits and exams, plus corresponding reports. There were no charges for courses of medical treatment or medications. The facts here could not represent a more textbook case of the types of reports required by section 4603.2(b)(2). Petitioner appears to readily admit that the reports corresponding to each examination were not served on the employer/carrier along with the itemized bills Petitioner argues that prior to 2020 there was no requirement to serve a medical report before Defendant's obligation to pay is triggered. Petitioner is off point. The issue is not whether Defendant has an obligation to pay, but whether there is liability for penalty and interest. It is well established that as a pre-requisite to entitlement to penalty and interest, Defendant must be provided with a properly documented itemization of services along with any required reports[2]. This requirement has been in place for all versions of Labor Code section 4603.2 during the period of time that Petitioner provided medical treatment services in this case.

Petitioner's argument that "many charges billed by doctors, including in this case, are for services which do not generate a medical report" is patently false as it pertains to this case. Here, for every single medical examination listed in Petitioner's itemized statements and ledgers, there is a corresponding charge for a medical report. The only charges billed by Petitioner which potentially doesn't require a report would be for missed appointments, but there is no fee schedule value for missed appointments.

Additionally, Petitioner argues Defendant "waived" any issue regarding "perfection" of the lien. Again, perfection of the lien is not at issue. The issue is penalty and interest. There is nothing for Defendant to waive in that regard because it is Lien Claimant's burden to prove entitlement to penalty and interest. Labor Code section 5705 sets forth that the burden of proof rests upon the party or lien claimant holding the affirmative of the issue. Thus, as stated affirmatively, Petitioner has the burden to prove that it is entitled to penalty and interest. It is not Defendant's burden to prove that Petitioner is not entitled to penalty and interest. Petitioner did not meet its burden in that regard. The lack of any waiver is also set forth in the case of Kunz v. Patterson Floor Coverings,

[2] Kunz v. Patterson Floor Coverings, Inc. (2002) 67 CCC 1588, 1592-95 (appeals board *en banc*). See Martinez v. Sifling Brothers, 2016 Cal. Wrk. Comp. P.D. LEXIS 461

Inc. (2002) 67 CCC 1588, 1592-95 (appeals board en banc) where it was held that a defendant's failure to specifically object to a lien on the basis of reasonable medical necessity (or on any other basis) does not result in a waiver of that objection under section 4603.2.

Finally, Petitioner asserts in its statement of facts that it is presumed that the Court has made a finding that CIGA is immune from statutory penalties and interest. To the contrary, the Court has made no such finding. The finding regarding penalty and interest is grounded only in Petitioner's failure to establish its burden that it served its itemized billing and required reports on the carrier. The decision has nothing to do with the liability of CIGA in general for penalty and interest.

MEDICAL-LEGAL CHARGES

It is odd that in the Petition, Petitioner stated the grounds for removal twice, did not state the proper grounds for reconsideration, and then made no argument regarding the issue that would be subject to a removal analysis. In any event, the Court did not defer the "issue" of medical-legal charges. That issue was not submitted for decision as it had never been raised. Had it been raised, Petitioner would have been required to prove all of the elements of the medical-legal portion of its lien such as whether there was a contested claim at the time services were provided, and whether the services were reasonably, actually and necessarily incurred, and whether the services were requested by a party. As a matter of due process, the Court has reserved jurisdiction over those charges since neither party was on notice that medical-legal charges would be at issue. Thus, not only is Petitioner not substantially prejudiced or irreparably harmed by such reservation of jurisdiction, it is helped or perhaps even saved.

IV
RECOMMENDATION

For the foregoing reasons, the undersigned WCALJ recommends that the Petition for Reconsideration and Removal be **DENIED**.

DATE: 6/5/23

Jeffrey L. Morgan
WORKERS' COMPENSATION
JUDGE