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WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

JESSICA SENQUIZ, *Applicant,* vs. **CITY OF FREMONT; YORK INSURANCE,** *Defendants.*	**Case No. ADJ5829433** **(Oakland District Office)** **OPINION AND DECISION AFTER RECONSIDERATION**

10 We previously granted reconsideration to further study the issues presented by this case. This is
11 our Decision After Reconsideration.

12 In the August 25, 2017 Findings and Order, the workers' compensation administrative law judge
13 (WCJ) found that, on January 26, 2015 and July 22, 2015, authorized transforaminal epidural steroid
14 injections were performed by lien claimant Fremont Surgery Center. The WCJ also found that
15 defendant, through the bill review process, refused to pay for two of the three levels injected for each
16 date of service. The WCJ found that this dispute was not subject to independent bill review (IBR) and
17 that the WCAB has jurisdiction. The WCJ deferred all other issues.

18 Defendant contends that the WCJ erred in finding that the WCAB has jurisdiction over this
19 dispute, arguing that the sole dispute is the amount payable under the official medical fee schedule
20 (OMFS) which is a dispute subject to IBR. Defendant argues that Fremont Surgery Center's lien should
21 be dismissed because lien claimant failed to timely seek IBR. Defendant also contends that it properly
22 objected to lien claimant's bills based on incorrect coding, arguing that the bills did not comply with the
23 National Correct Coding Initiative (NCCI) and that NCCI applies to billing pursuant to the OMFS.

24 We have considered the Petition and we have reviewed the record in this matter. We have
25 received a Report and Recommendation on Petition for Reconsideration (Report) from the WCJ
26 recommending that the petition be denied. For the reasons set forth below, we will rescind the WCJ's
27 decision and issue a new decision finding that the dispute is subject to IBR.

BACKGROUND

Applicant sustained an admitted industrial injury to her lumbar spine on September 18, 2007. The underlying case resolved on December 2, 2009 by stipulated award which included provision for future medical care.

On January 26, 2015 and again on July 22, 2015, applicant underwent three separate epidural steroid injections at the Fremont Ambulatory Surgery Center that utilization review authorized each time. After both sets of procedures, lien claimant submitted a bill for $5,800.00, which included a charge for each level injected and a charge for fluoroscopy connected to the injections.

Defendant conducted bill reviews and paid $558.81 for the first bill and $674.80 for the second bill. Defendant offered the following reason for reducing the charges: "Service/Item included in the value of other services per CCI edits. Related service could be on separate bill" (Exh. 101, February 11, 2015 explanation of review (EOR) for January 26, 2015 procedure; Exh. 103, September 2, 2015 EOR for July 22, 2015 procedure.) Each time, lien claimant filed a letter requesting reconsideration. In response to lien claimant's requests, the employer issued second bill reviews, upholding the original bill reviews. Lien claimant did not request IBR within the timeframe allowed after either second review.

In the Report, the WCJ framed the issues and her determination as follows: "...I determined that the Board has jurisdiction to determine a dispute over defendant's denial of liability for duplicative services that was not done in accordance with the Official Medical Fee Schedule..." (Report, p.1.) The WCJ explained:

> In the petition for reconsideration, as well as in its multiple trial briefs, defendant claims that it has not contested liability for any issue other than the amount due under the fee schedule, and so, FSC's failure to submit the "disputed bill" to IBR is fatal. I disagree.
>
> The employer has contested liability for payment of services performed by claiming that such services are not payable pursuant to Medicare's CCI editing process. Defendant's contention presents two problems. The first is defendant's assertion that it has not contested liability for any issue other than the amount due under the fee schedule. Actually, this is not true. Where a service is performed and the employer is claiming that $0 is the reasonable amount for that service, it is not contesting the reasonable amount of the payment; instead, it is contesting liability for that payment. Defendant has claimed that lien claimant performed duplicative services and that defendant is not liable for payment of such pursuant to Medicare's

> CCI editing process. If the fee schedule reduces a bill due to duplication of services, that is an issue for IBR. Here, the fee schedule does not adopt or incorporate the CCI edits for Ambulatory Surgery Centers (ASC); thus, the defendant's denial of liability for such duplicative services is not based on the fee schedule.
>
> Defendant argues that all Medicare rules are part of the fee schedule including the CCI edits. Defendant misconstrues Labor Code section 5307.l(a), which only states that the OMFS shall be in accordance with applicable Medicare rules. The Labor Code does not adopt or incorporate the Medicare rules as defendant suggests. To the contrary, Labor Code 5307.1 delegates to the Administrative Director the task of adopting the OMFS and the Administrative Director has expressly adopted the CCI edits as part of the Physician Fee Schedule. (See Cal. Code Regs., tit. 8, § 9789.12.13 ["The National Correct Coding Initiative Edits ("NCCI") adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule."].) The Administrative Director has not adopted such language under the Ambulatorv Surgery Center (ASC) portion of the fee schedule. (report, pp.3-4.)

ANALYSIS

After reviewing the relevant statutes and regulations, we conclude that disputes over the coding of procedures are disputes over the amount payable under the OMFS and are subject to IBR.

Senate Bill No. 863 (2011-2012 Reg. Sess. chaptered as Statutes 2012, chapter 363 (SB 863)) added language to Section 4603.2 of the Labor Code[1] setting "forth requirements for the second review that a medical provider may request (and must request) prior to seeking independent review of a bill." (*California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd.* (2014) 232 Cal.App.4th 543, 555 [79 Cal.Comp.Cases 1481].) SB 863 also added Section 4603.6 which discusses when an IBR may be requested, what will occur if an IBR is not requested within the prescribed time, how such a request is to be made, and how the IBR will be assigned to, and addressed by, an independent reviewer. Of particular relevance to the issues in this case, subsection (a) provides as follows:

> (a) If the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute, the provider may request an independent bill review within 30 calendar days of service of the second review pursuant to Section 4603.2 or 4622. If the provider fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue

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

> shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. (Lab. Code, § 4603.6(a).)

The only dispute is the amount of payment if there are no other issues that would impact whether defendant is required to pay the provider. It is well established that threshold issues that would entirely defeat an applicant's right to medical treatment must be resolved by the WCAB prior to proceeding to IBR. Threshold issues include whether applicant sustained an industrial injury, employment, statute of limitations, or insurance coverage. (Cal. Code Regs., tit. 8, § 10451.2(c)(1)(C).) Other potential disputes that could render IBR premature include disputes over whether the treatment is authorized, disputes over whether treatment is reasonable and necessary, and disputes over whether an applicant is entitled to treat outside of a medical provider network. No such disputes are present here.

In this case, the WCJ characterized the dispute as not subject to the OMFS because the fee schedule does not adopt and incorporate the NCCI edits which were the basis for defendant's objections to the bills. The WCJ is correct that the NCCI edits have not been formally adopted into the OMFS, but that does not preclude IBR's use of the edits in determining the correct amount owed to lien claimant. The NCCI edits are appropriately characterized as a tool utilized by IBR in applying and interpreting the OMFS to resolve disputes over amounts owed. Using the correct procedure code is in fact the first step in determining the proper amount to be paid to a provider. Once the correct code is identified, the corresponding authorized payment amount can be identified.

In the present case, the only issue that must be resolved in order to determine the amount lien claimant is owed under the OFMS is whether the relevant bills used the correct procedure codes. If the WCAB had jurisdiction to resolve that question, the WCAB would effectively be determining the amount due under the fee schedule. Pursuant to Section 4603.6(a), if "the only dispute is the amount of payment and the provider has received a second review that did not resolve that dispute," the provider must request IBR within 30 days or "the bill shall be deemed satisfied." In this case, the amount of payment depends upon the procedure codes used, but "the only dispute is the amount of payment." Therefore, we conclude that this dispute is subject to IBR and is not within the jurisdiction of the WCAB.

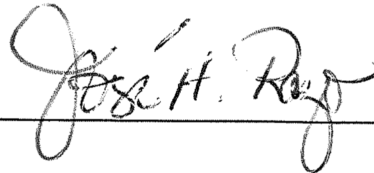
For the foregoing reasons,

IT IS ORDERED, as the Decision After Reconsideration of the Workers' Compensation Appeals Board, that Findings and Order issued by the WCJ on August 25, 2017 is **RESCINDED** and the following is **SUBSTITUTED** in its place:

FINDING OF FACT

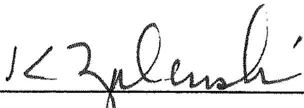
1. The dispute between defendant and Fremont Surgery Center over payment for the January 26, 2015 and July 22, 2015 dates of service is a billing dispute subject to independent bill review.

WORKERS' COMPENSATION APPEALS BOARD



I CONCUR,

JOSÉ H. RAZO



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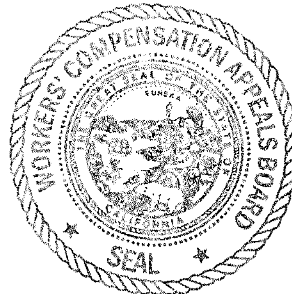

CONCURRING, BUT NOT SIGNING

FRANK M. BRASS

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

NOV 0 8 2017

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

COSTFIRST CORPORATION
FROST LAW
JESSICA SENQUIZ

MWH/ebc