WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

RUDY GALLARDO, ***Applicant,*** **vs.** **SOUTHERN CALIFORNIA EDISON, permissibly self-insured,** ***Defendant,*** **HUNTINGTON HOSPITAL,** ***Lien Claimant.***	**Case No. ADJ2200226 (POM 0277096)** **OPINION AND DECISION AFTER RECONSIDERATION**

We earlier granted defendant's petition for reconsideration of the December 23, 2013 Findings of Fact of the workers' compensation administrative law judge (WCJ) who found that "no express contract has been established which would deny jurisdiction to the WCAB pursuant to Labor Code Section 5304" and that "the provisions of Labor Code Section 4609(c)(2) have not been met." The WCJ further found that the "WCAB does have jurisdiction" over the dispute concerning the lien claim of Huntington Hospital (Huntington), and that the $43,870 amount claimed by Huntington pursuant to the Official Medical Fee Schedule (OMFS) in addition to the $18,050 already paid by defendant constitutes a reasonable fee for the hospital services Huntington provided applicant.

Applicant's claim of industrial injury to his low back and right shoulder was earlier settled by compromise and release as approved by the WCJ on February 12, 2013.

Defendant contends that the WCAB lacks jurisdiction over the fee dispute and that it is not liable to Huntington for the additional amount found by the WCJ because it earlier paid $18,050 to Huntington in accordance with the express agreement between Huntington and Blue Cross of California (BCC), which established the amount to be paid consistent with Labor Code sections 4906 and 5304.[1]

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

The WCJ's December 23, 2013 decision is reversed as our Decision After Reconsideration. The $18,050 fee paid by defendant to Huntington by way of the chain of contracts was pursuant to an "express agreement fixing the amounts to be paid" as described in section 5304, and under that section the WCAB does not have jurisdiction over the fee dispute. Huntington's contention that BCC did not follow the terms of their contract in accordance with section 4906 does not change the fact that the WCAB is without jurisdiction because there is an express agreement fixing the amounts to be paid. A different forum must be used by Huntington to adjudicate its breach of contract claims.

BACKGROUND

On April 23, 2003, applicant admittedly sustained industrial injury to his lower back in the course of his employment by Southern California Edison (Edison), permissibly self-insured. The claim was settled by way of a compromise and release agreement as approved on February 12, 2013.

Applicant received medical treatment in the form of two back surgeries performed at Huntington, and was hospitalized from March 10, 2008 through March 14, 2008 for the first surgery, and from August 5, 2009 through August 6, 2009 for the second surgery. Huntington billed $130,610.59 for the services it provided, but was paid $18,050.00 by BCC on behalf of Edison. Huntington filed a workers' compensation lien for the $112,560.59 balance it claimed was due, but it was subsequently stipulated that the total fee allowed by the OMFS is $61,920.00, and Huntington amended its claim to $43,870.00, which is the difference between the $18,050.00 paid by BCC and the $61,920.00 allowed by the OMFS.

The fee dispute was presented at a lien trial on August 22, 2013 and September 30, 2013. Two contracts were ultimately received into the record.[2] The first was a 23 page January 1, 2002 "Comprehensive Contracting Hospital Agreement" (CCHA) made between BCC and Huntington (Defendant's Exhibit A). The second was a seven page August 1, 2006 "Workers' Compensation Network Access Agreement" made between Edison and "BC Life & Health Insurance Company," which

[2] According to the August 22, 2013 Minutes of Hearing, Huntington initially objected to both the documents and the WCJ marked them for identification with the expressed the intention to "make a ruling for the parties on the admissibility of those exhibits when we reconvene." According to the September 30, 2013 Minutes of Hearing, the parties stipulated at that time that the two documents were "true and accurate copies of the referenced agreement[s]." In finding 8 of her December 23, 2013 Findings of Fact, the WCJ found that the two exhibits are "deemed admitted into evidence" based upon the parties' stipulation as to their authenticity.

is identified in defendant's petition as a BCC subsidiary (Defendant's Exhibit B). Following the trial and briefing of the parties the WCJ issued her December 23, 2013 decision as described above, finding that defendant is obligated to pay an additional $43,870.00 to Huntington pursuant to the OMFS.

In her Report the WCJ distinguished the facts underlying the decision of the Workers' Compensation Appeals Board (Appeals Board) panel in *Tri-City Medical Center v. Workers' Comp. Appeals Bd.* (*Streeter*) (2010) 75 Cal.Comp.Cases 790 (writ den.) (*Streeter* or *Tri-City Medical*) from the facts in this case, writing as follows:

> "The contention by defendant that the present matter is remarkably similar to that of *Tri-City Medical Center*...does not take into account an issue raised in the present case which is distinguishable. In the matter of *Tri-City Medical Center* it was noted the lien claimant did not identify any specific failure of disclosure or notification which it contended violated the requirements of Labor Code Section 4609. Also that lien claimant, Tri-City, was provided timely notification of the 'other payors' with whom the defendant had contracted. In the present case lien claimant, Huntington Hospital, submitted evidence (exhibit '5') of a demand made on defendant, Southern California Edison, for service of a copy of an express agreement in compliance with Labor Code Section 5304 and Labor Code Section 4609. No evidence was offered at the lien trial to sustain the contention that defendant met its burden of proof to establish the entitlement to pay lien claimant an amount less than the Official Medical Fee Schedule based on a claimed PPO discounted contract agreement."

DISCUSSION

Section 5304 provides as follows:

> "The appeals board *has jurisdiction over any controversy* relating to or arising out of Sections 4600 to 4605 inclusive, *unless an express agreement fixing the amounts to be paid* for medical, surgical or hospital treatment as such treatment is described in those sections *has been made between the persons or institutions rendering such treatment and the employer or insurer.*" (Emphasis added.)

In this case, Huntington contends that there is no express contract between it and defendant Edison regarding the amount the hospital is to be paid for its services. However, there is a contract between Huntington and BCC that includes Huntington in BCC's network and that agreement specifies the amounts that will be paid for various hospital services. (Defendant's Exhibit A.) There is also a second contract between BCC's subsidiary and Edison granting Edison access to BCC's network.

(Defendant's Exhibit B.) The question is whether those two agreements constitute a chain of contracts that is an "express agreement" as described in section 5304, which fixes the amount Huntington is to be paid for the services it provided the injured worker in this case.

The question of whether such a chain of contracts constitutes an "express agreement" under section 5304 that relieves the WCAB of jurisdiction over a fee dispute was answered in the affirmative in *Streeter*. In *Streeter*, the Appeals Board panel relied upon the plain language of section 5304 to hold that the chain of contracts in that case constituted an "express agreement" under section 5304 that fixed the amount to be paid, noting that its decision was consistent with earlier Appeals Board decisions, as follows:

> "Our prior determination in this matter is consistent with recent decisions, where we held that the language in the Blue Cross 'Comprehensive Contracting Hospital Agreement,' expressly provides for Blue Cross to contract with 'Other Payors' to provide access to a hospital's medical services. Such 'Other Payors' are noted to consist of other *insurers,* including workers' compensation insurers. (See e.g., *Recovery Resources, Inc. v. Workers' Comp. Appeals. Bd. (Gordon)* (2009) 74 Cal. Comp. Cases 881 [writ denied]; See *Ferguson v. Handee Market* (2005 Cal. Wrk. Comp. P.D. Lexis 22[)]; *Waters v. Los Angeles Clippers* (2005 Cal. Wrk. Comp. P.D. Lexis 15.)
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> "In *Ferguson, supra*, an Appeals Board panel held that the Labor Code section 5304 requirement that there be an 'express agreement' does not require that there be a single agreement between the parties. In that case, the initial contracting agreement between the lien claimant hospital, St. Joseph and First Health, a PPO, acted as a chain of agreements to create a bridge between the defendant insurer and St. Joseph. As with Tri-City here, St. Joseph entered into the contract with a PPO with notice of certain provisions that encouraged the utilization of its services by additional affiliates and other payors of the PPO, such as the defendant. Thus, it was not unreasonable to read the contracts together to find that there was an 'express agreement' between St. Joseph and defendant, which triggered the application of Section 5304.
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> "Similarly, in *Waters, supra*, an Appeals Board panel reversed the WCJ's determination that a specific contract must exist between the medical services provider and the workers' compensation carrier in order to create a binding agreement between the two and found, instead, that a chain of contracts may provide a bridge from the medical services provider to the carrier.
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> "In *Gordon, supra*, the case involved the same Comprehensive Contracting Hospital Agreement between Blue Cross and the lien claimant hospital as entered between Blue Cross and Tri-City here. In that case, an Appeals Board panel found the agreement between Blue Cross and SCIF…to utilize the hospital's services as an 'other payor,' at the preferred rates negotiated by Blue Cross."

As can be seen, the WCJ accepted Huntington's argument that this case involves a different factual scenario than presented in *Streeter* and the earlier Appeals Board panel decisions described in that case because the defendant in this case did not show that it complied with all of the provisions of the CCHA and section 4609.[3] In particular, Huntington claims that defendant failed to disclose a summary of all other payors eligible to pay the negotiated rate under the CCHA as required by paragraph 4.10 of the CCHA, and as described in section 4609(b). In the view of the WCJ as expressed in her Report, a defendant is obligated to present evidence showing that it acted in compliance with all the provisions of the CCHA and section 4609 or the WCAB will retain jurisdiction over the dispute between the parties pursuant to section 5304.

The WCJ's view is indirectly supported by the decision of the Appeals Board panel in *Streeter*. In that case the provider contended that the "chain of contract" interpretation of section 5304 denied it due process because it was being precluded from raising its claim that the second contract between Blue Cross and the insurer violated the "silent PPO" provisions disallowed by section 4609. The Appeals Board panel in *Streeter* wrote in response that the record did not show such a violation of section 4906 as asserted by the provider, which suggests that the WCAB will adjudicate contract compliance and section 4609 issues when it hears a lien claim fee dispute.

We do not find that *Streeter* holds that the WCAB will adjudicate breach of contract claims and section 4609 issues pursuant to its section 5304 jurisdiction over lien claim fee disputes. Instead, the panel in *Streeter* simply noted that the provider's agreement with Blue Cross in that case expressly contemplated the addition of workers' compensation insurers to the Blue Cross managed care network, and the fact that other payors were added after the initial contract was made between Blue Cross and the provider was not inconsistent with the contract language. However, that observation about the terms of the contracts at issue was *not* the basis for the decision in *Streeter*. Instead, the panel in *Streeter* expressly identified the reason for its decision in that case as follows:

> "In the law of contracts, 'express' means only that the agreement be 'stated in words,' (Civil Code section 1620), rather than implied by the conduct of the parties. (See Witkin, Calif. Law, Contracts, § 11.) Section 5304 does

[3] Attached as Appendix A to this decision is the complete text of section 4609 as of the date of this decision.

> not require that the agreement of the parties be expressed within the four corners of a single contract. Rather, it is entirely appropriate to review the terms of several inter-related contracts *to determine whether there was an agreement to fix the amounts to be paid* for medical treatment between Tri-City and SCIF as an 'other payor…'
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> "Accordingly, we shall, as our Decision After Reconsideration, affirm our prior determination that *the Workers' Compensation Appeals Board is without jurisdiction, pursuant to Labor Code section 5304*, over the controversy relating to or arising from the medical, surgical, or hospital treatment provided by Tri-City Medical Center herein *because an 'express agreement' fixing the amounts to be paid was made between the persons or institutions rendering the treatment and the employer or insurer.*" (Emphasis added.)

Here, as in *Streeter*, there is an express agreement between the provider in this case, Huntington, and Blue Cross fixing the amount Huntington is to receive for the services it provided. As in *Streeter*, there is a second agreement between Blue Cross and Edison that allows Edison the benefit of the reduced rate negotiated with Huntington. The fact that Edison is permissibly self-insured does not change the analysis because self-insurance is treated as insurance under the workers' compensation law. (*Denny's Inc. v. Workers' Comp. Appeals Bd.* (*Bachman*) (2003) 104 Cal.App.4th 1435 [68 Cal.Comp.Cases 1].) Under section 5304, the chain of contracts in this case precludes the WCAB from exercising jurisdiction over Huntington's lien claim for additional fees. (*Streeter*, *supra*.)

Huntington's contention that Blue Cross breached the CCHA and was not in compliance with section 4906 cannot be adjudicated before the WCAB because section 5304 disallows WCAB jurisdiction when there is an "express agreement fixing the amounts to be paid," as there is in this case. In that regard, we note that Article IX of the CCHA addresses "Dispute Resolution," and provides that Blue Cross and Huntington are to make a good faith effort "to resolve any problems or disputes that may arise" under their agreement, and if that effort is not successful "any problem or dispute arising under" the agreement "shall be arbitrated."

The WCJ's December 23, 2013 Findings of Fact is reversed, and a new finding is entered that there is an express agreement fixing the amount Huntington is to be paid for the hospital treatment it provided the injured worker in this case, and under section 5304 the WCAB is without jurisdiction to adjudicate Huntington's lien claim for additional fees.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the December 23, 2013 Findings of Fact of the workers' compensation administrative law judge in ADJ2200226 is **RESCINDED,** and the following is substituted in its place:

FINDINGS OF FACT

1. RUDY GALLARDO, born on while employed on 04-23-2003 as a construction material handler by Southern California Edison, permissibly self-insured, sustained injury arising out of and occurring in the course of employment to his lower back and claims to have sustained injury arising out of and in the course of employment to his right shoulder.

2. Defense exhibits 'A' and 'B' were listed in the Stipulations and Issues Pre-Trial Statement form and are deemed admitted into evidence. As stated in the Minutes of Hearing and Summary of Evidence dated September 30, 2013, it was stipulated by the parties those exhibits were true and correct copies of the referenced agreements.

3. Defendant's Exhibits 'A' and 'B' are a chain of contracts that constitute an express agreement fixing the amount that lien claimant Huntington Hospital is to be paid for the hospital services it provided applicant, and the Workers' Compensation Appeals Board has no jurisdiction under Labor Code section 5304 to adjudicate Huntington Hospital's lien claim for additional fees.

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IT IS FURTHER ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the lien claim of Huntington Hospital in ADJ2200226 is **DISMISSED.**

WORKERS' COMPENSATION APPEALS BOARD

FRANK M. BRASS

I CONCUR,

DEIDRA E. LOWE

CONCURRING, BUT NOT SIGNING
RONNIE G. CAPLANE

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

APR 0 8 2014

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

HUNTINGTON HOSPITAL
REID STEINFELD, ESQ.
BAGBY, GAJDOS & ZACHARY

JFS/abs

APPENDIX A
***Gallardo v. Southern California Edison* ADJ2200226**
Labor Code section 4609

(a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in any payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed by the contracting agent to the provider in advance and shall actively encourage employees to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage employees to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged employees to use the list of contracted providers if the employer provides information directly to employees during the period the employer has medical control advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to employees; or in advance of a workplace injury, or upon notice of an injury or claim by an employee, the approaches may include, but are not limited to, the use of provider directories, the use of a list of all contracted providers in an area geographically accessible to the posting site, the use of wall cards that direct employees to a readily accessible listing of those providers at the same location as the wall cards, the use of wall cards that direct employees to a toll-free telephone number or Internet Web site address, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly during the period the employer has medical control. However, Internet Web site addresses alone shall not be deemed to satisfy the requirements of this paragraph. Nothing in this paragraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of an employee. A payor who otherwise meets the requirements of this paragraph is deemed to have met the requirements of this paragraph regardless of the employer's ability to control medical treatment pursuant to Sections 4600 and 4600.3.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the employees to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the employees to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 15 business days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreements with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the employees to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and any other contracting agent that buys, leases, or otherwise obtains the list of contracted providers.

A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the employees to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the employees to use the list of contracted providers when obtaining medical care.

(6) If the payor's explanation of benefits or explanation of review does not identify the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered, the contracting agent shall do the following:

(A) Maintain a Web site that is accessible to all contracted providers and updated at least quarterly and maintain a toll-free telephone number accessible to all contracted providers whereby providers may access payor summary information.

(B) Disclose through the use of an Internet Web site, a toll-free telephone number, or through a delivery or mail service to its contracted providers, within 30 days, any sale, lease assignment, transfer or conveyance of the contracted reimbursement rates to another contracting agent or payor.

(7) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the network with which the payor has an agreement that entitles them to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The provider shall include in the request a statement explaining why the payment is not at the correct contracted rate for the services provided. The failure of the provider to include a statement shall relieve the payor from the responsibility of demonstrating that it is entitled to pay the disputed contracted rate. The failure of a payor to make the demonstration to a properly documented request of the provider within 30 business days shall render the payor responsible for the lesser of the provider's actual fee or, as applicable, any fee schedule pursuant to this division, which amount shall be due and payable within 10 days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this subdivision. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(A) Describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b), and demonstrates compliance with paragraph (1).

(B) Identifies the contracting agent with whom the payor has a written agreement whereby the payor is not required to actively encourage employees to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Contracting agent" means an insurer licensed under the Insurance Code to provide workers' compensation insurance, a health care service plan, including a specialized health care service plan, a preferred provider organization, or a self-insured employer, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide health care services to employees for work-related injuries.

(2) "Employee" means a person entitled to seek health care services for a work-related injury.

(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of subdivision (c), "payor" means an insurer licensed under the Insurance Code to provide workers' compensation insurance, a self-insured employer, a third-party administrator or trust, or any other third party that is responsible to pay health care services provided to employees for work-related injuries, or an agent of an entity included in this definition.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(e) This section shall become operative on July 1, 2000.