STATE OF NEW JERSEY
NEW JERSEY DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
DIVISION OF WORKER'S COMPENSATION

WILFREDO GARCIA **Petitioner,** **vs.** **NJ WILDLIFE MANAGEMENT, LLC and NICOLA GRANATA, individually** **Respondent.**	**MT. ARLINGTON VICINAGE** **CP#: 2015-24560** **DECISION AND RULING ON CLAIMS OF BILLS OF MEDICAL PROVIDER/INTERVENORS**

APPEARANCES:

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This matter comes before me for decision following a complicated and lengthy progress through the Division of Workers' Compensation involving issues of employment determination, an uninsured employer, claims of intervenors seeking payment of medical bills for services

rendered at the hospital and by physicians where the injured Petitioner, Wilfredo Garcia[1], was transported following his fall and injury on July 8, 2015, and objections raised by the uninsured employer to any payment of medical charges.

BACKGROUND

The Claim Petition in this matter indicates that Wilfredo Garcia was injured on July 8, 2015, while working at a business known as Stone Surfaces, Inc. ("Stone Surfaces"). Initially, the Petitioner had filed a Claim Petition against Stone Surfaces, but shortly afterwards, on September 25, 2015, filed a separate Claim Petition for his injury and the incident naming as his employer, New Jersey Wildlife Management LLC and Nicola Granata, individually as the officer of that business. Both claim petitions pertained to injuries sustained when the Petitioner fell from a roof where he was attempting to replace a drain pipe. While in the course of trying to replace the drain pipe, he had fallen from the roof and had the drain pipe fall on top of him, striking him on the head causing a fracture of his skull and rendering him unconscious.

Stone Surfaces answered that it was not the employer of the Petitioner. On October 13th of 2015 an Answer was filed on behalf of the Respondent, New Jersey Wildlife Management LLC and Nicola Granata, the corporate officer. [2] In its answer, it denied employment, denoted no workers' compensation coverage on the date of the accident and therefore, was uninsured; admitted to having knowledge of the accident of July 8th, and contained a demand for medical records, examinations, and diagnostic studies pertaining to the claim.

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[1] For ease of reference, the Petitioner may be hereinafter referenced as "Garcia" rather than by his full name. No disrespect is intended by such reference.

[2] For ease of reference the Respondent will be referenced in this decision as "NJWM" and will be understood to refer to both the business, New Jersey Wildlife Management LLC and Nicola Granata, individually as the officer of New Jersey Wildlife Management LLC.

MOTIONS TO JOIN THE UEF AND TO INTERVENE

While the two claim petitions were pending, a motion to join the Uninsured Employer's Fund ("UEF") Fund was filed by Petitioner's counsel on October 27, 2015, and re-filed on January 13, 2016. As required by the Division Rules within Subchapter 7 of N.J.A.C. 12:235-7.1 et seq., accompanying that Motion was a Certification of the Petitioner in which he asserted he was hit by a pipe that fell from a building, striking him on the head and severely injuring him.

The Petitioner's Certification which was required by N.J.A.C 12:235-7.3, noted that as a result of his injury, he required immediate medical care and transportation to the Hackensack Medical Center where he was admitted from July 8th to the 11th of 2015. Although the Certification mis-numbers and duplicates paragraph numbers, attached to that motion were those requisite records and bills referenced in the Division Rule. More specifically, it included the name and address of all treating physicians and the name and address of Hackensack University Medical Center which was the hospital, laboratory or other facility where treatment was received; a certified and complete copy of the hospital record; copies of all medical reports from the hospitals and treating physicians; and a detailed listing of medical expenses which have been incurred, the dates the medical services were provided, the names of individuals and entities providing such services, and the sources and amounts of such payments.

Identified in paragraphs of his Certification, were the treating physicians: Dr. Hooman Azmi-Ghadimi who was a neurosurgeon employed with North Jersey Brain & Spine Center ("NJBSC")[3], Dr. Setu Dalal, and Dr. Hilda Castillo. Billings from the various entities associated with the Petitioner's medical care, inclusive of the required ambulance transport, were set forth as

[3] In later proceedings, Dr. Azmi-Ghadimi, has been referenced as Dr. Azmi and it is that name which will hereafter be used by the Court. Also, the name of the group under which he was billed is Comprehensive Neurosurgical DBA North Jersey Brain & Spine Center.

well. The alleged medical expenses totaled in excess of $200,000. The absence of insurance to cover any of those injury-associated expenses was set forth by the Petitioner's Motion to join the UEF.

An Order was entered by Judge Kovalcik on February 9, 2016, which joined the UEF in these proceedings. Motions to Intervene were also filed by Hackensack University Medical Center and NJBSC. On the same date that the UEF was joined, an Order was entered to permit Hackensack University Medical Center ("HUMC") to intervene to seek payment for any related-hospital services rendered to this Petitioner. An Order entered on September 27, 2016, permitted NJBSC to intervene as well. None of the Motions were opposed.

APPLICATION TO ENTER MEDICAL BILL PAYMENT ORDER

Subsequent to the joinder of the medical intervenors, and due to the conflicting positions of the two Respondents, the disputed issue of employment was resolved by the Honorable Kenneth J. Kovalcik, S.J.W.C., following a bifurcated trial on the consolidated claim petitions.

Judge Kovalcik heard testimony from the Petitioner and other proffered witnesses for NJWM and for Stone Surfaces. In his decision, he held that there was no co-employment between NJWM and Stone Surfaces. In regard to the position espoused by NJWM, he found Nicola Granata to be a "totally incredible witness." The Claim Petition filed against Stone Surfaces was dismissed. Judge Kovalcik found that Garcia was an employee of NJWM, was injured in the course of his employment and was entitled to workers' compensation benefits [4/25/2017 – T5:11-15].

As he held that the sole employer was NJWM, and that entity was uninsured, the case was transferred to the Uninsured Employer's Fund list before this Court. The attorneys then proceeded to prepare their files in order to proceed to a conclusion of the case. At the case listing on February 13, 2018, counsel discussed Petitioner's counsel drafting an order that would permit payment by the UEF of the unpaid medical bills that related to the July 2015 accident. However, when the parties appeared at the June 19, 2018-UEF listing date, counsel for the uninsured-employer

(NJWM) voiced an objection to, and dispute of, the entry of any Order permitting the UEF to pay incurred medical bills and expenses.[4]

The Court considered the oral objection to fall within the scope of the Division UEF Rules, specifically N.J.A.C. 12:235-7.4 (b), which states:

> b) Any dispute under this section concerning the treating records, bills, physician's report or UEF request for other medical documentation or information shall be determined by the judge after a hearing upon ***oral*** or written ***motion*** by the UEF ***or another party***. [Emphasis added].

Upon the entry of a judgment for the payment of reasonable medical expenses incurred by the petitioner, and the failure of the employer to pay that judgment, the UEF is required to make payment of the medical expenses. N.J.S.A. 34:15-120.2(1). The uninsured employer may then be the subject of proceedings by the UEF to have a judgment entered against it for the payments made by the UEF. That judgment may be entered against not only the uninsured employer but also the active officers of the business, docketed in Superior Court, and then collected by the UEF from the uninsured employer and/or its officer(s). N.J.S.A. 34:15-79.; N.J.S.A. 34:15-120.3. Clearly, the party-NJWM has an interest in any award that establishes an amount payable for medical expenses incurred by a worker whose injury arose out of and in the course of his/her employment. Therefore, NJWM and Nicola Granata, individually, have an interest in a determination of the amount of medical bills/expenses which the UEF may pay and later seek to recover from NJWM or Nicola Granata, individually, and were entitled to a hearing on their objections.

HEARING ON APPLICATION TO ENTER MEDICAL BILL PAYMENT ORDER

As noted previously, objections were raised by counsel for the uninsured Respondent and its corporate officer, Nicola Granata, to the entry of a Consent Order affixing the amount of the

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[4] It should be noted that there is a single day within the three-week cycle, on which UEF cases are heard. This vicinage handles all of both the Mt. Arlington and Lebanon uninsured cases on that date. The UEF attorney is assigned by the State UEF to appear in other vicinages on all of the other dates of the cycle. Consequently, the parties must insure their attendance on the UEF assigned date so that the State UEF attorney may participate.

bills for medical providers who rendered emergency, life-preserving medical care to the Petitioner, Wilfredo Garcia, as a consequence of the accident of July 8, 2015. Counsel's oral objection was to the amount of the bills and argued that the charges were not compliant with the statute which requires:

> … fees and other charges for such physicians' and surgeons' treatment and hospital treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services.

See N.J.S.A. 34:15-15.

The obligation and the liability of the employer to provide workers' compensation coverage for its workers is mandatory and imposed by statute. N.J.S.A. 34:15-10. It is a liability imposed by the clear language of N.J.S.A. 34:15-15 and recognized in the case of Benson v Coca Cola Co., 120 N.J.Super 60 (AppDiv 1972). Benson holds that employers which fail to fulfill their statutory obligation to provide for medical treatment for employee work-related injuries, **shall** be liable for medical treatment which the employer's refusal or failure to provide have compelled the Petitioner to obtain. An advance request to the employer is required by the language of the statute, "unless the injury occurred under such conditions as make impossible the notification of the employer" or the "the circumstances are so peculiar as shall justify the expenditures assumed by the employee" for the medical care.

This employer, as determined by an earlier hearing, was uninsured at the time of Garcia's accident. By virtue of its failure to obtain coverage either thru buying a policy of insurance or by self-payment of such benefits, and by selecting to forgo compensation insurance coverage, it made a choice to not provide for treatment for work-related injuries for its employees. In fact, NJWM failed to make arrangements to cover the medical expenses of its injured worker even after learning of this Petitioner's accident and severe injury. According to the testimony before Judge Kovalcik, the employer's officer, Nicola Granata, had visited Garcia while he was at the hospital and, as later

testimony on this motion indicated, had been later-contacted by the hospital on those medical expenses. When contacted, Mr. Granata denied both employment and refused responsibility for the medical bills for Garcia.

As noted in the certified hospital record which was attached to the Motion to Join the UEF and later was admitted as a part of the record as HUMC-3 in Ev., Garcia's medical expenses were incurred and qualified under both exceptions of the statute which would have otherwise required an employee request to precede incurrence of employer bill responsibility. More specifically, the record reflects Garcia was taken by ambulance from the site of injury. While in the emergency room, he was in a coma with a GCS level 15 that deteriorated to a level 9, was unconscious and began seizing with a rapid decompensation to a state of unresponsiveness. An emergency craniotomy was required to be performed and he was moved from the emergency room directly to surgery. I find that such circumstances presented both a situation where he was unable to make a request and where the circumstances were so peculiar, i.e. unresponsive in a decompensating coma state, to justify the incurrence of expenses for the medical transport to, and treatment at, the hospital.

Although I find that the liability of NJWM for payment of Garcia's medical expenses is required as a matter of law, the amount payable for the medical treatment is a different issue. The language of the statute, requires that such a determination is to be made based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services. N.J.S.A 34:15-15.

No objection as to the amount of the charged expenses was vocalized by NJWM at the time of the joinder of the medical providers and facilities when their motions to intervene were filed. The two intervention motions included attached documentation and certifications. Nor were objections made by NJWM at the time the matter was pre-tried for the prior hearing before Judge Kovalcik. However, this Court accorded NJWM the opportunity to proffer a basis for objection

to those bill amounts, and entered a Scheduling Order on July 10, 2018. The Scheduling Order contained a timetable and requirements for the identification of any proposed experts for either NJWM, HUMC or NJBS; identification of the qualifications of those experts; proffers of anticipated testimony, and dates when materials were to be produced/exchanged and testimony to begin. Counsel for the objecting uninsured party was provided an opportunity to make a proffer by way of expert designation and certification, that there was a true dispute as to the sought medical expenses. Production of any proposed witness would precede the production of medical intervenor witneses.

When the conditions of the Scheduling Order were not fully met over a period of several months and necessitated repeated adjournments of trial dates in an effort to permit NJWM to produce its proposed expert witness, NJWM was barred from the production of its proposed designated witness. Noting that a distinction exists between the burden of production and the burden of persuasion, this Court held that the two intervenors continued to bear the latter burden, and were instructed to produce their witnesses to establish that the medical expenses sought were "reasonable and based upon the usual fees and charges that prevail in the same community for similar physician's, surgeons and hospital services" as required by N.J.S.A. 34:15-15. Cross-examination by counsel for NJWM was permitted.

WITNESSES

Hearings were held on five dates on which no testimony was taken. Those particular dates were as follows: July 10, 2018, August 10, 2018, July 31, 2018, October 2, 2018, and June 11, 2019. Motion-trial testimony was taken from the following witnesses: Lee Goldberg who is the billing and financial manager for North Jersey Brain & Spine (November 13, 2018); and Annette

Burke who is HUMC's Supervisor for External Collection (March 19, 2019).[5] No witness was produced by Petitioner's counsel in regard to any of the medical bills.

Following the testimony of Ms. Burke, there was confusion as to whether or not any monies had been received by HUMC from New Jersey Charity Care for the medical services rendered to Wilfredo Garcia as a consequence of his July 8, 2015-work accident, and whether there were any unpaid HUMC-charges outstanding for the care of the Petitioner. This confusion prompted a Motion to be filed on or about April 13, 2019, by the employer's counsel seeking the dismissal of the hospital charges for any service other than ambulance services.

The Court subsequently issued *sua sponte,* a July 23, 2019-Order to Reopen the Record for the production of a knowledgeable witness by HUMC. The witness was to explain whether Charity Care funds had been provided to, or utilized by, HUMC on this claim, and if so, to provide information for the Court as to the impact on this pending claim of payment from such a third party source. In response to the Court Order, HUMC produced Laura Weaver, Regional Director for Patient Financial Services for HUMC (9/3/2019).[6]

No other witnesses were produced by any party or by the UEF.

WITNESS TESTIMONY

As stated, there were three witnesses who actually testified in this matter. I found all three to be credible and knowledgeable in their areas of testimony. Each was familiar with the subject matter on which she testified, and none evidenced any effort to evade or avoid questioning by any of the parties or the court. Although employed by the respective entity which produced the witness, the individual witnesses were not interested in the ultimate outcome of the matter and had no

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[5] The Court was out on medical leave for the entire month of February 2019 and proceedings were unable to be scheduled during that period.

[6] Since the earlier testimony by Annette Burke, it appears HUMC has become known as Hackensack Meridian Health which includes both HUMC and Palisades Medical Center. For simplicity, it will continue to be designated as HUMC within this opinion.

benefit to be personally achieved. Each continued to remain poised during what at times appeared to be contentious cross-examination, but ultimately provided explanations that amply explained what may have facially appeared to be an inconsistency, but in reality was not. I found each to be credible.

North Jersey Brain & Spine

Produced by NJBS as its witness, was Lee Goldberg. Ms. Goldberg had attended a two-year course for medical practice administration in Paramus, New Jersey in 1976. The courses included education in medical coding, proper coding, diagnosis codes, CPT Codes, procedure codes, etc.. Following her completion of the requisite courses, she had received a certificate in Medical Administration from the Taylor Business Institute.

She has been the billing and financial manager for NJBS for eighteen (18) years since 2001, and for two other neurosurgical groups before that, resulting in her possessing a total of approximately twenty-eight years of experience. At NJBS, she also supervises a group of ten employees who daily perform the billing and collection, appeals, and payments and billing for the group to submit to insurance companies for services rendered by the physicians of NJBS. Included among her responsibilities, she must determine what are the reasonable fees for the surgeons to charge for services provided and is aware of what fees are actually paid for those services. She had testified once before in a matter involving Empire Blue Cross Blue Shield, and that testimony took place within Bergen County.

In order to perform her current billing function, she is familiar with the reading of the group's physicians' operative reports, medical records and consultation reports so that the services rendered may be identified and coded. She has also taken online classes and courses at hospitals so that she be current and familiar with the various carriers' billing and Medicare billing requirements.

As the group's fourteen (14) surgeons are neurosurgeons, they perform brain and spinal surgeries, and are on staff at HUMC which is a State Level II Trauma Center that receives a number of emergency cases. In fact, the group's physicians are the only trauma neurosurgeons for HUMC which is the only trauma center in Bergen County. NJBS has no contracts with any insurance carrier and is out of network, but does participate with Medicare for billing. NJBS surgeons are not covered by Charity Care for their services. She further testified that on behalf of NJBS, she has handled the appeals of denials or low payments with Medicare as well as "pretty much all carriers" naming at least four, and has acted similarly with self-funded and fully insured plans.

NJBS offered her as an expert in medical coding and billing for neurosurgeons for hospital and office procedures. Furthermore, she testified as to the usual, customary and reasonable rates for neurosurgeons with a neurosurgical practice in North Jersey. Based upon her education, years of training and actual decades of performance of the coding and billing for hospital and office procedures, she was found by the Court to be qualified as an expert in the areas for which she was offered.

The Petitioner's neurosurgeon was Dr. Azmi. Dr. Azmi is a Board Certified neurosurgeon and member of the trauma neurosurgeons who are members of NJBS. The practice's normal business practice is to have the hospital operative reports dictated by the physician on the same day the service/surgery is rendered. The office obtains a copy of the report for its physician from the hospital, which is read and coded by the witness. The copy of that report is required to be maintained as part of the office records to fulfill the State licensing requirements of the doctor providing the service. She testified that in 2015, she would have been the individual who coded and billed for Garcia's services.

The operative and consult reports for the petitioner were contained within P-2 in Ev.. According to the exhibit, the history of the present illness for which the procedure was performed, noted Garcia had been involved in an incident at work where he was struck by a pipe that fell on

his head. Once in the hospital, it was noted that he had become increasingly obtunded, and began seizing, thereby presenting an emergency situation. See P-2 in Ev and HUMC-3.

According to Ms. Goldberg, after reading the procedures of P-2 in Ev., she would, and did, then consult the CPT[7] Code Book prepared by the American Medical Association (AMA). Her testimony indicated that the AMA CPT Code book is relied upon as authoritative by insurance companies and Medicare for medical coding and modifiers, and she has utilized it in her work.

In regard to the specific services rendered to Garcia, she identified the July 8, 2015-services to be coded as CPT 62005 for a craniotomy to remove the skull pieces from the brain, and CPT code 62141 for a cranioplasty to repair the crushed skull. An additional charged consultation CPT code of 625 was withdrawn by the provider and payment is not being sought for that service. P-4 in Ev. which was prepared by the witness for this Petitioner and retained as a company business record, indicates that Code 62005 was billed $47,200 and Code 62141, $53,000. The total bill for those two services provided by Dr. Azmi was $100,200. The diagnosis that required the services was CPT code 800.16 indicating skull fracture. As of the date of the testimony, no payment had been made on the bill.

Ms. Goldberg testified that NJBS utilizes the rates or charges referenced in the FAIR Health[8] charges to reflect, when possible, what is the usual, customary and reasonable (UCR) charges for varied procedures. The practice utilizes that data which has been culled out by a company known as Optum. The data specifically identified codes within the neurosurgical

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[7] CPT stands for Current Procedural Terminology which identifies the procedure in a standard manner utilized in the health industry.

[8] FAIR Health maintains and publishes a national database of fees organized by CPT codes and broken down into percentiles for geographic regions or zip codes. Furthermore, it is recognized within the New Jersey PIP Schedules to be evidential of the reasonableness of a fee charged for automobile accident claims although the State PIP law specifically excepts services provided at Trauma Hospitals from its schedules. See University Physicians Assoc v Transport Drivers, Inc., 2017 N.J.Super Unpub LEXIS 2102; N.J.A.C. 11:3-29.4. There appears to be no reason for this Court not to utilize such a source for guidance.

specialty and the fees paid within a specific geographic area and zip code for those services. The data is published and updated annually in a report designated "Customized Fee Analyzer." It is the source upon which NJBS relies for its billed charges submitted or payments received.

In fact, the witness testified that P-6 in Ev. represented the Customized Fee Analyzer relied upon by NJBS to set its fees in this matter. She walked the court through the explanation of the various columns of information and noted that the information was annually updated. The Fee Analyzer reports the charges for specific codes collected by the company for payments made by providers and Medicare within a geographic area and specialty, and then breaks it down into percentiles, such as 80th percentile, 85th percentile, 90th percentile. P-6 in Ev was restricted to Bergen County and reported fees paid for the services of neurosurgeons, as drawn from the previous calendar year of 2014. The NJBS charges for services rendered in 2015, were testified to be based on those reported fees and were billed at the Optum Report's 90th percentile figures.

In addition, the witness testified that she would save insurance company "Explanation of Benefit" (EOB) responses for those carriers or companies that might pay less than the submitted charge, and organized those EOB's by the year. That information is used by the practice as documentation for NJBS to appeal and argue that the submitted charge is what should be paid by a carrier should it pay "less than submitted" for a NJBS charge. The witness testified that she personally reviewed the practice's records and retrieved the EOB comparables used at this hearing and marked in a packet as P-7 in Ev..

The witness provided 6 pages of comparable EOB payments made by varying payors for CPT Code 62141 [cranioplasty larger than 5 cm]. On each of the six comparables, NJBS had billed $53,000 for CPT Code 62141 services, but been paid less. [9] The medical group chose not to pursue or appeal the payments made by those payors. It is her understanding that the charges

[9] Horizon BCBS paid $50,350 on two; AmeriHealth and Aetna paid $42,400 on their three charges; and United Health on a second submission paid $41,223.81.

reported to Optum for its Fee Analyzer reports are what the carriers have paid on a specified CPT Code. She did not provide any information on the total incidents for which charges were submitted on CPT Code 62141 in 2015, or any of the other years she had also pulled for her comparables on the CPT Code for 62005 where carriers paid less than the submitted NJBS-charge.

Although she had searched NJBS records for the years 2011-2015 for CPT Code 62005 [elevation of depressed skull fracture], the witness had only one EOB which was located for such a procedure, and that one charge was from 2011. That payment that had been made by United Healthcare. For that CPT Code in 2011, NJBS had charged $28,000 and had been paid the full amount by United Healthcare. As had been stated earlier, the fees charged for the neurosurgical services increase annually as reflected within the 90th percentile reported on the Optum Fee Analyzer report. In the opinion of the witness, the service should be paid as charged in 2015 due to the fact that it was an emergency life-saving procedure.

Testifying within her field of expertise, the witness' opinion was that CPT code 62005 should be paid at $47,200 and CPT code 62141 should be paid at $53,000. As reflected in P-4 in Ev., those were the charges submitted for the two codes for services rendered by Dr. Azmi to the Petitioner, Wilfredo Garcia. Her opinions were expressed within a reasonable degree of the medical coding profession.

Hackensack University Medical Center

Hackensack University Medical Center called Annette Burke as its first witness. Ms. Burke has been employed for twenty years within that facility. For the last twelve of those years, she has held the position of Supervisor for External Collection Agency, and previously worked within the hospital's billing department. Seven years prior to beginning employment with HUMC, she had worked for Valley Hospital in their billing department. She testified that she was certified in both ICD-9 and CPT Coding, and as a consequence is familiar with the medical billing, coding and the

processing of the bills for services rendered at HUMC. The codes utilized are generated by the government and reflected in the HCFA Code Book and the CPT Code Book.

In her capacity as the Supervisor for External Collection Agency, she would supervise 18 collection agencies which are tasked in the collection of payment bills not paid by insurance whether it is personal injury, workers compensation, Medicare, Medicaid, health or auto. In a given year, HUMC generates over 36,000 bills in a month, and she interacts on only those that go to the collection agencies.

Ms. Burke was qualified as an expert as to what the charges and fees are for services and treatment rendered by HUMC relevant to the proponent's establishment of what would constitute a reasonable fee in the community for such hospital services as rendered to Wilfredo Garcia. She testified that all of her answers had been provided within a reasonable degree of her expertise and experience in the fields for which she was admitted to testify as an expert.

She testified that the hospital utilizes an internal software program known as Chargemaster into which information for care would be entered by the treating doctors and nurses. The information is thereafter transported into what is known as a universal bill. Chargemaster, generates the bill utilizing information as to the hospital's cost factors and overhead as generated yearly by independent experts based upon regional data. In the case of HUMC, it has been designated as a Level 2 Trauma Center. The nature of the injury upon admission, will also affect the charge. The services are reflected, and then coded, and are maintained as the medical record for the patient. The medical records for the admission and treatment of the Petitioner were admitted as HUMC-3.[10]

HUMC-1 was the universal bill generated by HUMC for Wilfredo Garcia for services rendered him at the hospital during the time period between July 8, 2015 to July 11, 2015. The

[10] The same medical records, with the attached certification of completeness from the appropriate custodian, were submitted in connection with the Motion earlier made to join the UEF.

particular bill was one that had gone through her department and she was in charge of the bill once it was sent to her department. She provided the court with information as to the various entries on HUMC-1 in Ev., and the source for the entry. For example, the treating professional would enter the code that appears in Column 1, which would then generate the description explanation of Column 2. On the Garcia bill, the first entry was for Code 0201, Intensive Care – surgical; the second, Intensive Care – Intermediate, Code 0206. Column 3 would provide more detail. However, as the patient was rendered the service as an inpatient, there were only two entries in that column; coded as 0201 and 0206. Column 4 was blank. Column 5 specified the number of units of the service utilized by the patient, or 1 day for Code 0201 and 2 days for 0206. Column 6 is the price or total charges for that entry for code 0201, or $8,231; Code 0206, $14,020.

The bill was admitted as a HUMC business record obtained by the witness from the hospital records as they are normally maintained within the department of which the witness is the supervisor. It reflected that the charges of HUMC for the 3 day-period in question, was for $83,950.20. Page three of the exhibit was for the ambulance transportation of the injured person to the hospital on July 8, 2015. That bill was for $2,813. The total charge was $86,763.20.

On the face of the bill, the hospital had listed under the "Payer Name," HUMC Charity Care. The witness testified that once the patient has come into the hospital and there is an indication that there is no insurance, the entry of that designation will cause the bill to be automatically recalculated to adjust it to a figure that would be twice the sum that Medicare would pay for such charges. She further testified that as to the Garcia bill, no payment had been made by Charity Care.

The witness also identified HUMC-2 as an EOB processed through Hartford to HUMC for a service designated by code 201. She testified that where there are negotiated contracts between HUMC and an insurance carrier, that the hospital would be paid its charge according to the negotiated contract rates between HUMC and the carrier. She had personally retrieved HUMC-2 from the hospital business records maintained by it in regard to payments the hospital received for

representative services that had been coded identically to those reflected for this petitioner on HUMC-1. The charges for pages 1-2 of the exhibit were paid under a contract between Horizon Casualty Services and HUMC for a worker's compensation claim. The time period when the services was rendered was in March of 2015 – only months before the accident of Mr. Garcia. The bill was for 5 days of ICU surgical days at a charge of $41,63, or $8,326 per day.

Page 3 of HUMC-2 showed an EOB charge also processed through Hartford to Horizon Casualty Services for HUMC ICU-Intermediate Care under Code 206. The service was rendered in August of 2015, only a few weeks after the Petitioner's incident. Based upon the contracted rate, HUMC was paid $12,723.94 for the four days. The charge was submitted based on 4 days for a total charge of $28,040, or $7,010 per day, for a workers' compensation claim.

On questioning by counsel for the UEF, the witness testified that the inpatient bill had been paid by Charity Care. According to Ms. Burke, the bill was currently noted in the system as zero balance for the inpatient stay. With a balance due was $0, confusion as to why the intervenor was involved in the matter was apparent and unexplained at that point. Only the mobile intensive care ambulance services, as referenced on the last page of HUMC-1, reflected a balance due from the Petitioner.

The parties then rested, and the employer, NJWM, moved for dismissal of that aspect of the hospital's claims. However, upon Court review I determined that I needed to hear from further witnesses relative to Charity Care funds and this claim. By Order of July 23, 2019, I exercised the authority recognized by Handleman v Marwen Stores Corp., 53 N.J. 404, 411 (1969) and Polulich v J.G. Schmidt Tool Die & Stamping Co., to reopen the proofs and ordered the hospital to produce a witness knowledgeable with the facts pertaining to both topics and Mr. Garcia's bills, and to provide all parties an advance Certification of such proposed witness, his/her resume and copies of anticipated relevant proofs.

On September 3, 2019, HUMC produced Laura K. Weaver in response to the Court's Order. She is employed as the Regional Director for Patient Financial Services for HUMC and Palisades Medical Center, which due to their merger is now known as Hackensack Meridian Health. Her testimony proved invaluable to clarification of the apparent confusion which arose at the end of Ms. Burke's testimony.

Ms. Weaver oversees the Financial Assistance Office of HUMC which includes the processing of Charity Care and Medicaid as sources for financial assistance for patients seen at the hospital. She has held the Regional Director title for approximately a year. Prior to that, she has worked within and held various titles within the financial department of HUMC for approximately 22 years.

The process followed at the hospital for a patient, requires that the hospital immediately have financial counselors attempt to locate information from the patient if possible, or others, confirming the presence or absence of insurance for the medical treatment to be provided at the hospital. If there is no commercial insurance available, the staff must then confirm the potential eligibility of that patient for Medicaid. It is only after eligibility for Medicaid is ruled out, that the patient is then processed for payment by NJ Charity Care as a payment source of last resort.

How the patient arrives at the hospital is also a factor in the manner of processing, as is the type of claim: work related, automobile accident or other ambulance transport, or pre-scheduled procedures. As the case indicates that the Petitioner arrived through the emergency room and was ultimately admitted from there, she was requested to focus on that particular process. This Motion does not involve individuals who may present to the hospital for pre-arranged services.

In emergency cases, the counsellor would obtain information regarding income, assets, family size, residency, and documentation to support the information provided by the injured party or someone with them. The application remains within the hospital. Once the coverage and billing system is updated and other payment sources are determined to be non-existant, the hospital claim

is submitted to the State for payment as charity care. Internally, Wilfredo Garcia's application was approved within HUMC as eligible for financial care submission for a 100% payment by Charity Care.

Once the hospital exhausted its efforts to ascertain workers' compensation payment due to the employer's denial of employment, and made that assessment, it submitted the bill to the State Department of Human Services by submission to the State's contracted clearance agency, Molina Medicaid Solutions (Molina). Molina is the agency that will determine if the bill may actually be paid with State Charity Care funds. In the case of the Petitioner, his submitted claim was submitted on July 6, 2016 to Molina which denied the claim. Based upon Error Codes 1411 and 0087, the denial was based upon the hospital surgeon not being enrolled in the state database system as a participating physician. The denial was dated July 7, 2016 and included within Weaver-1 in Ev., Exh. C. As a result, HUMC was prohibited from utilization of state funds allocated to HUMC for Charity Care funds for payment of the Garcia bill.

The bill submitted, HUMC-1 in Ev., would indicate $0 balance due as there is no payment due from the petitioner. However, the hospital has not been compensated for its services and payment remains outstanding. Had there been no other payment source with liability for such medical care, there would have been no payment sought from the patient. Consequently, there remains unpaid and outstanding a claim for payment for the inpatient services, inclusive of surgery, for $83,950.20 (HUMC-1, pp1-2) and ambulance services of $2,813 (HUMC-1, p3).

Ms. Weaver explained that when litigation is involved in the effort to receive recovery for unpaid services, that the Customer Service and Bad Debt, Credit and Collections department of Ms. Burke would be involved. Ms. Burke's department would work in the area of patient and patient responsibility. Ms. Weaver's department would have the responsibility to attempt to seek payment from Charity Care or Medicaid where no other source is available.

DISCUSSION AND CONCLUSION

The New Jersey Workers Compensation Act is humane social legislation to be liberally construed to achieve its beneficent purposes. Torres v Trenton Times Newspaper, 64 N.J. 458, 461 (1974). As stated *supra*, the obligation and the liability of the employer to provide workers' compensation coverage for its workers is mandatory and imposed by statute.

New Jersey does not provide a fee schedule for medical services to be paid under the Workers Compensation Act. Rather, liability for medical expenses is confined to:

> ... fees and other charges for such physicians' and surgeons' treatment and hospital treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services.

See N.J.S.A. 34:15-15.

I find that the services required to be provided to Wilfredo Garcia were emergent services, the circumstances of which precluded any advance request for authorization and, indeed, were provided in the face of life-threatening deterioration. See P-2 in Ev.; HUMC-3 in Ev.. I further find that his employer, NJWM and Nicola Granata, individually, by failing to uphold the statutory mandate to provide coverage for work injuries of employees of NJWM, are responsible for the medical care provided to Wilfredo Garcia.

Aside from the evidence within the hospital record (HUMC-3 in Ev.), these hearings were not intended to address any subject other than to affix or determine what the "UCR" would be for the intervenors' medical bills. However, I will note that should there be no other evidence produced hereafter on the issue of any entitlement to temporary disability benefits for the Petitioner, that it would appear that a limited period of temporary disability benefit entitlement could be affixed based upon HUMC-3 in Ev.. The Petitioner's stay at the hospital did not extend beyond the time required for a period of compensable lost time and temporary disability benefits, but the discharge summary indicates that he needed to have a follow up with Dr. Aziz and Dr.

Dalal one week after that discharge. His hospital records indicate he had an abnormal EEG disclosing a left parietal occipital cerebral dysfunction interpreted to be consistent with structural abnormalities, and no indication he was cleared to return to any work. Follow up care was ordered to permit removal of the staples from where the cranioplasty was performed, and to address the medications prescribed at discharge which had also included not only narcotics but also Keppra as a seizure prophylaxis following subarachnoid hemorrhage.

Crediting the hospital physician's assessment of the petitioner's need for medical care beyond the discharge date, any claim for temporary disability benefits could only be made to extend to the one further week specified within those hospital records. There was no evidence of post-discharge medical care required beyond that period which would take the Petitioner up to July 17, 2015. At a bare minimum, it would not have been until the staples had been removed from his head that he could have been restored, as much as he could be, from the effects of his injury. That is what N.J.S.A. 34:15-15 requires. See Hanrahan v Township of Sparta, 284 N.J.Super 327, 334 (App.Div. 1995), *cert den'd* 143 N.J. 326 (1996); also Johnson v Hamilton Twp, 2013 N.J.Super Unpub. LEXIS 728, p. 9. Consequently, evidence produced in the file as of this time, would support only a 13-day period of temporary disability at the rate required by statute, and the parties should be prepared to advise the court of their position on the topic before the matter proceeds to any permanency aspet.

In regard to the in-hospital charge for consultation services, that was withdrawn by the proponent and the Court need not address that charge. This hearing dealt only with the physicians', surgeons' and hospital services, and a determination of what would be the usual, customary and reasonable charges for same. When the employer failed to provide a witness for any scheduled trial date at which the UEF could participate resulting in an Order precluding such witness, it left only the medical providers' witnesses to testify in this matter. They were subjected to cross-examination by counsel for both the employer and for the UEF. Counsel for neither of those parties

produced any evidence to counter or introduce any evidence of alternative, similar charges and payments in the community where the services were rendered for similar services. There were no rebuttal witnesses provided by any party, and the witness required by the Court to be produced was subjected to cross-examination by all parties.

The evidence discloses that HUMC is a Level II Trauma Center. Mr. Garcia was treated for his crushed skull by a Board Certified neurosurgeon, Dr. Azmi, both in the emergency room following ambulance transport, and in the operating room where the craniotomy and cranioplasty were performed in a life-threatening situation. HUMC-3 in Ev.

The witnesses of the parties were qualified by their years of experience and training in coding utilizing the CPT codes as well as use of the Optum Fee Analyzer and its FairHealth data. The witnesses also were familiar with payments, both fully or partially, made to their respective employers and by participating in any subsequent appeals of diminished payments made to their employers. Such expertise obtained by training, education and experience qualified them to provide testimony and opinions. However, even had the Court precluded those witnesses, specifically Ms. Goldberg and Ms. Burke as experts, they continued to be credible fact witnesses with expertise that the Court found helpful. The testimony of Ms. Weaver provided excellent clarification of what otherwise appeared to be an inconsistency between what was paid, or payable, for hospital services that had been submitted to, and denied by, state Charity Care. The bills for the hospital, ambulance and surgeon remain unpaid and uncompensated up to the present date.

I concur with Coalition for Quality Healthcare v New Jersey Department of Banking and Insurance, 358 N.J.Super 123 (AppDiv 2003), that paid fees, rather than charged fees, provide a more accurate measure of what is a "usual, customary, and reasonable" fee for services provided in a community. The Court will apply that approach to this case and will consider what has been paid in the community or geographic area encompassing Hackensack for the noted services rather than what was billed by the provider.

The use of the 2015 Optum Fee Analyzer data for neurosurgeons and its contained FairHealth data which identifies those payments for specified CPT Codes within the geographic area of the provider, is reasonable to be utilized in this matter. The testimony disclosed that NJBS had only six charges which were not paid at the amount it charged for CPT Code 62141. Although Ms. Goldberg had testified that the medical group utilized the 90th percentile of the 2015-Optum Neurosurgical Fee Analyzer data for the basis of charges for its physicians' services, that was not confirmed by the Exhibit P-6 in Ev.. The billed charge of $53,000 appears to be closer to an average of what P-6 in Ev indicated to be the paid fees for such charges using the reported 85th and 90th percentiles. Averaging those two percentiles would reflect an average of $52,922.50. In comparison, the average paid for CPT Code 62141 on the submitted six comparables of P-7 in Ev., averaged $44,854.

Had there been evidence on the total number of NJBS-received payments made for CPT Code 62141 during 2015, the Court would have been in a position to determine if there was a better indicator of what sum would represent the customary, usual and reasonable fee paid for CPT Code 62141, and if the submitted comparables represented 6 out of 600 or 6 out of 7 payments on NJBS-submitted charges.

In the absence of such information, I believe that neither of the proposed approaches is truly ideal. However, the provider is entitled to a determination of a sum for its rendered services consistent with the standard of N.J.S.A. 34:15-15 and based on the submitted evidence. Therefore, I find that the amount that represents the usual, customary and reasonable fee in the community in which the NJBS surgeon's services was provided for CPT Code 62005 is $48,888. That figure represents a calculation of an average derived from the comparables' average payments (P-7 in Ev.) and the amount obtained by averaging the 85th and 90th percentiles for fees paid for CPT Code 62141 (P-6 in Ev.).

The customary, usual and reasonable fee for CPT Code 62005 is in a somewhat different position. There is no evidence that any payer has paid less in the community in which the service was rendered than what has been billed for that code. The only comparable produced was from 2011 and is outdated. Consequently, the evidence of what has been paid for that CPT Code is best reflected in P-6 in Ev. However, as with the earlier code, the actual charge by NJBS does not correlate exactly with either the 85th or the 90th percentile but is between the two. Applying the same approach as previously noted, I will average the fees of those percentiles to arrive at what is the customary, usual and reasonable fee payable for a cranioplasty greater than 5 cm. Therefore, I find that the customary, usual and reasonable fee for that procedure code of CPT Code 62005 is $47,192.

The charges of Hackensack University Medical Center were relatively consistent between what was submitted for the larger charges for the ICU treatment identified in HUMC-1 and in HUMC-2, its proposed comparable. In fact, HUMC-1 contained *lower* charges for the similar coded care. The evidence indicates that the reason the bill was unable to be paid by Charity Care was because the hospital physicians (not the NJBS physician) were not registered in the States Charity Care system as providers. The denial was not because the billing was not customary, usual or reasonable for the geographic area in which it was provided. It remains unpaid. The charges for the hospital ($83,950.20) and its ambulance service ($2,813) will be allowed as reflected in HUMC-1.

DECISION

Based upon the facts I have set forth within this decision, and following a review of the exhibits and testimony submitted by the parties, I find that the medical fees of the intervenors have been incurred on behalf of Wilfredo Garcia as a result of the compensable incident of July 8, 2015, and are found to be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services. Those fees that are

payable by the Respondent, and by Nicola Granata individually under N.J.S.A. 34:15-15 are as follow:

1. The surgical services of Dr. Azmi of North Jersey Brain & Spine as identified by CPT Codes 62500 and 62141 shall be $96,080;
2. The hospital services rendered by Hackensack University Medical Center for the Petitioner's care from July 8, 2015 to July 11, 2015, shall be allowed in the amount of $83,950.20; and
3. The ambulance services rendered by Hackensack University Medical Center to transport the Petitioner from the scene of the accident to the hospital shall be allowed in the amount of $2,813.

In light of the failure to produce any evidence on the other medical bills that may have been incurred by the Petitioner as a consequence of his July 8, 2015 compensable injury, no other medical fees are allowed.

Counsel for the Petitioner shall consult with the UEF Attorney and prepare the appropriate Order so that the Court may assess counsel fees calculable on the obtained medical benefits as well as reporters costs for proceedings on this case.

The form of Order shall state that the payments are due from the uninsured employer, NJ Wildlife Wildlife Management LLC, and from Nicola Granata, individually. Should payment not be made within the time periods set forth by N.J.S.A. 34:15-120.2, then the Uninsured Employers Fund may make such conditional payments in accordance with, and as may be permitted by, the Workers' Compensation statute and Division Rules, and seek reimbursement from NJ Wildlife Wildlife Management LLC, and from Nicola Granata, individually, as permitted by law.

Costs for the nine transcripts of the proceedings, inclusive of the date this decision is placed on the record, shall be at $150 for each date, or $1,350, shall be assessed against the Respondent.

When the matter is next listed by the Division, the Court will hear the position of the parties as to any entitlement of the Petitioner to temporary disability benefits and thereafter, the Respondent's application on the pending Motion of the Respondent to dismiss the claim petition for failure to prosecute same and schedule or attend medical examinations for permanency determination.

Dated: Oct 21, **2019**

D. GAYLE LOFTIS, J.W.C.