WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

FELISA RODRIGUEZ, ***Applicant***

vs.

BUILDING CARE SYSTEMS;
STATE COMPENSATION INSURANCE FUND, ***Defendants***

Adjudication Number: ADJ9258442
Santa Rosa District Office

OPINION AND ORDER GRANTING PETITION FOR RECONSIDERATION AND DECISION AFTER RECONSIDERATION

We have considered the allegations of the Petition for Reconsideration and the contents of the Report of the workers' compensation administrative law judge (WCJ) with respect thereto. Based on our review of the record, and for the reasons stated below, we will grant reconsideration, rescind the June 22, 2023 Findings and Order, and return this matter to the trial level for further proceedings and a new decision.

In her Report, the WCJ stated that:

> Applicant sustained an industrial injury on September 13, 2013 to her head, back and digestive/GERD during the course of her employment as a maintenance worker for Building Care Systems. This case settled via Stipulations with Request for Award on February 7, 2019.
>
> Subsequently, on December 3, 2020, Integrated Pain Care San Francisco filed a lien for medical treatment in the amount of $55,352.10 for physician visits with Dr. Martinovsky from 7/10/14 through 6/2/20. (LC Exh. 1.)
>
> The majority of the lien stems from a Functional Restoration Program. On December 30, 2015, Dr. Martinovsky submitted a Request for Authorization for 160 hours of a functional restoration program. (LC Exh. 6.) The fax cover sheet shows that State Compensation Insurance Fund received the Request for Authorization on December 30, 2015 at 6:21 p.m. (LC Exh. 6.) Less than 5

business days later, Utilization Review (UR) requested additional information from Dr. Martinovsky on Tuesday, January 5, 2016. (Def. Exh. D, p. 49, 1/5/16.) Specifically, UR requested the following:

> Please provide current current [sic] subjective and objective findings for necessity of the requested functional restoration program. Does the patient have significant loss of ability to function independently due to pain? Has the patients [sic] symptoms of depression been address? [sic] Has the patient failed medications or are current medications ineffective.
> (Id.)

Having received no response, another request for additional information was sent on January 14, 2016 seeking the specific constituents of the requested program, including modalities requested, duration and frequency. (Def. Exh. D., p. 52, 1/14/16.) Simultaneously, on January 14, 2016, UR conditionally non-certified the prospective request for 160 hours of a functional restoration program between 12/30/15 and 6/28/16 because the necessary information was not provided. (Def. Exh. D, p. 55, 1/14/16.)

Another Request for Authorization was issued by Dr. Martinovsky on February 25, 2016 for 80 hours functional restoration program. UR certified 30 hours of a functional restoration program. (Def. Exh. D, p. 73, 3/2/16.) Defendant rendered payment for the authorized medical treatment. (Def. Exh. A.)

This matter proceeded to trial on recovery of the Integrated Pain Management lien in the amount of $55,352.10. An F&O issued finding that the lien claimant is not entitled to payment for non-certified medical treatment as the Utilization Review decisions were timely, the lien claimant failed to sustain their burden that they are entitled to charges in excess of what was paid, and the lien claimant has been fully compensated for services that are the subject of their lien.

(Report, at pp. 2-3.)

At the time of the UR decision at issue here, former section 4610(i)(1) provided as follows in relevant part:

> Except for treatment requests made pursuant to the formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request. The request for authorization and

supporting documentation may be submitted electronically under rules [*12] adopted by the administrative director.

(Former Lab. Code, § 4610(i)(1), amended by Stats. 2019, ch. 647, § 6, eff. Jan. 1, 2020.)

AD Rule 9792.9.1 further provides in pertinent part:

(c) Unless additional information is requested necessitating an extension under subdivision (f), the utilization review process shall meet the following timeframe requirements:

(1) The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

...

(3) Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA.

...

(e) (3) For prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, [*13] or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

...

(f)

(1) The timeframe for decisions specified in subdivision (c) may only be extended under one or more of the following circumstances:

(A) The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination.

...

(2) (A) If the circumstance under subdivision (f)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

...

(3) (A) if the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent [*14] review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

...

(4) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written decision shall include the date the information was received and the decision shall be communicated in the manner set out in section 9792.9.1(d) or (e), whichever is applicable.

(Cal. Code Regs., tit. 8, § 9792.9.1 (c), (e) and (f).)

In its Petition for Reconsideration, lien claimant asserts that its Request for Authorization (RFA) was successfully transmitted at 4:45 p.m., on December 30, 2015, as evidenced on lien claimant's Exhibit 6, at p. 12, making it timely. (Petition for Reconsideration, at pp. 3:23, 4:6-9.) As quoted above, the WCJ found that "The fax cover sheet shows that State Compensation Insurance Fund received the Request for Authorization on December 30, 2015 at 6:21 p.m." (Report at p. 2.) Both assertions rely on page 12 of lien claimant's Exhibit 6, consisting of what appears to be a facsimile transmission report. However, we are not able to provide meaningful review here because there was no testimony at trial or other evidence interpreting the conflicting information shown on this report and the operative time of the transmission.

Decisions of the Appeals Board must be supported by substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd*. (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd*. (1970) 3 Cal.3d 312, [35 Cal.Comp.Cases 500];

LeVesque v. Workmen's Comp. Appeals Bd. (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) "The term 'substantial evidence' means evidence which, if true, has probative force on the issues. It is more than a mere scintilla, and means such relevant evidence as a reasonable mine, might accept as adequate to support a conclusion...It must be reasonable in nature, credible, and of solid value." (*Braewood Convalescent Hosp. v. Workers' Comp. Appeals Bd. (Bolton)* (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566].) The Appeals Board has the discretionary authority to develop the record when appropriate to provide due process or fully adjudicate the issues. (*McClune v. Workers' Comp. Appeals Bd*. (1998) 62 Cal.App.4th 1117, 1121-1122 [63 Cal.Comp.Cases 261]; see also *Tyler v. Workers' Comp. Appeals Bd*. (1997) 56 Cal.App.4th 389, 394 [62 Cal.Comp.Cases 924]; Lab. Code, §§ 5701, 5906.)

Therefore, we will grant reconsideration, rescind the WCJ's decision, and return this matter to the trial level for further proceedings as the WCJ determines appropriate, and for a new decision.