WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

ROQUE NERI HERNANDEZ, ***Applicant,*** **vs.** **GENEVA STAFFING, INC. dba WORKFORCE OUTSOURCING, INC.; TOWER POINT NATIONAL INSURANCE COMPANY, administered by TOWER SELECT INSURANCE,** ***Defendants.***	**Case No. ADJ7995806** **(Stockton District Office)** **OPINION AND DECISION AFTER RECONSIDERATION** **(En Banc)**

On August 16, 2013, an Appeals Board panel granted reconsideration on its own motion of its previous Opinion and Order of August 12, 2013 to further study the factual and legal issues.[1] Thereafter, to secure uniformity of decision in the future, the Chairwoman of the Appeals Board, upon a majority vote of its members, assigned this case to the Appeals Board as a whole for an en banc decision. (Lab. Code, § 115.)[2]

On May 30, 2013, a workers' compensation administrative law judge (WCJ) issued a Findings and Award (F&A), which found that applicant was entitled to medical treatment in the form of home health care services beginning on August 3, 2011 and continuing and awarded applicant payment for

[1] Commissioner Moresi, who was on the Appeals Board panel that issued the August 12, 2013 and August 16, 2013 orders no longer serves on the Appeals Board.

[2] En banc decisions of the Appeals Board are binding precedent on all Appeals Board panels and WCJs. (Cal. Code Regs., tit. 8, § 10341; *City of Long Beach v. Workers' Comp. Appeals Bd.* (*Garcia*) (2005) 126 Cal.App.4th 298, 313, fn. 5 [70 Cal.Comp.Cases 109]; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418 [67 Cal.Comp.Cases 236]; see also Gov. Code, § 11425.60(b).) In addition to being adopted as a precedent decision in accordance with Labor Code section 115 and Appeals Board Rule 10341, this en banc decision is also being adopted as a precedent decision in accordance with Government Code section 11425.60(b).

self-procured home health care services. Defendant sought reconsideration and contended that newly enacted Labor Code sections 4600(h) and 4603.2(b)(1) applied.[3]

Based upon our review of the relevant statutes and case law, we hold that:

(1) Sections 4600(h), 4603.2(b)(1), and 5307.8[4] apply to requests for home health care services in all cases which are not final regardless of date of injury or dates of service.

(2) The prescription required by section 4600(h) is either an oral referral, recommendation or order for home health care services for an injured worker communicated directly by a physician to an employer and/or its agent; or, a signed and dated written referral, recommendation or order by a physician for home health care services for an injured worker.

(3) Under section 4600(h), home health care services are subject to either section 5307.1 or section 5307.8. Section 5307.1 applies where an official medical fee schedule or Medicare schedule covers the type of home health care services sought. Otherwise, section 5307.8 applies.

In light of these holdings, we rescind the F&A and return the matter to the WCJ for further proceedings and a new decision from which any aggrieved party may timely seek reconsideration.

BACKGROUND

While employed as a machine operator for defendant, applicant sustained a severe crush injury to his right dominant hand on July 11, 2011. For more than three weeks after his injury, applicant was hospitalized at St. Mary's Medical Center and was treated there by hand surgeon Charles Lee, M.D. Applicant continued to treat with Dr. Lee and at St. Mary's for almost a year.

During his initial hospitalization, applicant had three surgeries on his hand. Once he was home,

---

[3] Unless otherwise stated, all further statutory references are to the Labor Code.

[4] Section 4600(h) states that home health care services are "subject to [s]ection . . . *5703.8*." The reference to 5703.8 must be a clerical error since section 5703.8 does not exist. Section 5307.8 concerns home health care services and we will consider that the phrase was intended to read that home health care services are "subject to [s]ection . . . *5307.8*." (Cf. *In re Thierry S.* (1977) 19 Cal.3d 727, 741, fn. 13 ["obvious mistake" in statute's cross-reference to another statute]; *Gray Cary Ware & Freidenrich v. Vigilant Ins. Co.* (2004) 114 Cal.App.4th 1185, 1193-1194 [courts may "correct an obvious and minor drafting error where necessary to effectuate the intent of the Legislature"].)

he developed a serious infection in his hand, which necessitated a fourth surgery on September 19, 2011. Then, on December 20, 2011, he had a fifth surgery. Further surgery on applicant's right hand has been recommended.

Hand surgeon Leonard Gordon, M.D., acted as the Agreed Medical Evaluator.[5] With respect to the condition of applicant's hand, Dr. Gordon concluded that:

> "It is evident that Mr. Neri-Hernandez has had a devastating injury to his right hand with a severe crush injury, and he has extremely severe pain and essentially no function.
>
> "He is not able to flex any of the fingers without extreme pain. He is not able to move the thumb away from the index finger so that he has no ability to pinch, grip, manipulate, or use the hand.
>
> "Combined with this, he has extremely severe pain when trying to move the hand in any way at all.
>
> ***
>
> "As it stands at this point, Mr. Neri-Hernandez has essentially lost all use of the right upper extremity."[6]

Applicant was cared for at his home by his spouse. A handwritten note on St. Mary's Medical Center letterhead dated November 11, 2011 states in its entirety that:

> "To Whom it may Concern,
>
> "This is to notify that Neri Hernandez Roque has been under the care of Dr. Charles K. Lee for severe injury to his right hand since 7-11-11 at which time he has needed constant care from his wife Adrianna Bayona.
>
> "Mr. Neri Hernandez will need continuous care as his ongoing treatment goes on. [sic]
>
> "If you have any questions please call our office at Pros at (415)750-55-88. [sic]
>
> "Sincere, [sic]
> Dr. Charles K. Lee"

---

[5] Dr. Gordon prepared reports on September 17, October 1, and November 5, 2012. Medical records from St. Mary's and from applicant's treating physician Mark Diaz, M.D., are not in evidence. Dr. Gordon commented in his September 17, 2012 report that he had reviewed four volumes of records from St. Mary's, and he briefly summarized those medical records. He also reviewed and briefly summarized medical records from Dr. Diaz.

[6] This summary by Dr. Gordon is contained in his Report of September 17, 2012.

What appears to be a signature for Dr. Lee is scrawled on the bottom of the letter.

On November 28, 2011, applicant's counsel wrote to defendant and enclosed the handwritten note by Dr. Lee.[7] The letter stated in its entirety that:

> "Attached please find Dr. Charles Lee correspondence dated November 11, 2011. Please allow this letter to serve as my formal request that you authorize the applicant's wife, Adrianna Bayona to provide in-home [sic] for the applicant.
>
> "If I have not received written confirmation of your authorization for the above requested treatment within 5 days, I will file for an Expedited Hearing on this matter."

In his November 5, 2012 report, Dr. Gordon opined that:

> "As far as the second question which relates to an attendant, I do feel that it is reasonable for the patient to have support, transportation, and attendant care at the rate of six hours per day. There does not appear to be any particular need for skilled nursing as at this time there are no bandages or unusual care that is needed, and this would be at the unskilled level."

On March 5, 2013, the parties appeared for an expedited hearing on the issue of home health care services. Applicant sought an order for home health care services provided by his spouse; an award "for retroactive payment . . . to the date of injury payable to the applicant as a medical benefit;" and attorney's fees. Applicant contended that his spouse's testimony was an adequate basis to determine the hourly rate of reimbursement. Defendant contended that the November 11, 2011 report by Dr. Lee was not a valid prescription for home health care services as it did not specify the type of care or number of hours of care required; that neither Dr. Lee's nor Dr. Gordon's report was sufficient to determine the type of care required; and that Senate Bill [SB] 863 controlled.

Applicant's spouse testified as follows:

They have been married for nine years. Up to the time of applicant's injury, she had worked fulltime as a teacher's assistant at a daycare center for fifteen years. Before applicant's injury, she took care of the house on weekends. Although she sometimes made dinner, he did the cooking. He took care of the yard, worked on the cars, did his own laundry, and did grocery shopping. After the injury, she was

[7] In its Petition for Reconsideration, defendant admits that it received this letter, but there is no evidence of when defendant received it.

laid off for missing time from work "because her husband needed her." She drew unemployment insurance from September 2011 to February 2013. Her last full year worked was 2010, and she has not worked outside the home since the injury.

Applicant was in the hospital for twenty-two days "and she stayed there to help and to take instructions from the doctors." She speaks some English but her husband does not, and there were no interpreters present. After he was released she took care of him at home, and she "was required to spend all day long with the applicant back then." She bathed him, gave him medicines, fed him and dressed him. She also went with him to San Francisco for his doctor's appointments and treatment. Applicant developed an infection in his hand, and when they saw Dr. Lee for the infection, he told her that she "had to clean the applicant up as they could not get a nurse." Dr. Lee gave her a letter in "November."

Currently, she spends less time taking care of applicant than before; she spends about six to eight hours a day doing so. She helps him with his medications three times per day and with applying his pain patches, opens his water bottles, shaves him, trims his moustache and nails, scrubs him, washes his head, helps him bathe and helps him to dress including changing from his pajamas and tying his shoes, and putting on his belt, pants, and jacket. He showers daily, and the showers take forty-five minutes to an hour. She drives him, takes care of the yard and the cars, prepares meals, and does his laundry. She last assisted him with the toilet about a year and a half ago.

On May 30, 2013, the WCJ issued the F&A. He found that applicant was entitled to payment "for self-procured medical care" beginning on August 3, 2011. He awarded services for 24 hours per day, 7 days per week from August 3, 2011 to November 4, 2012, and for 6 hours per day, 7 days per week from November 5, 2012 and continuing, and attorney's fees of 15%. He awarded payment based on applicant's spouse's regular hourly rate of pay at the day care center.

Thereafter, defendant sought reconsideration. Defendant contended that: (1) there was no substantial medical evidence to support the award of home health care services; (2) applicant did not have a prescription within the meaning of section 4600(h); (3) payment should not have been awarded directly to applicant because there was no evidence that applicant had incurred the expense; and (4) applicant's spouse did not submit an itemization of services pursuant to section 4603.2(b)(1).

We received an Answer from applicant. The WCJ prepared a Report and Recommendation on Petition for Reconsideration (Report) recommending that reconsideration be denied.

On August 12, 2013, an Appeals Board panel granted defendant's Petition for Reconsideration, rescinded the F&A and returned the matter to the WCJ. However, on August 16, 2013, the panel granted reconsideration of its August 12, 2013 Opinion in order to further review the case.

DISCUSSION

I. INTRODUCTION AND SUMMARY

Section 4600(h) states that:

> Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and subject to Section 5307.1 or [5307.8]. The employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription.

Section 5307.8 states that:

> Notwithstanding Section 5307.1, on or before July 1, 2013, the administrative director shall adopt, after public hearings, a schedule for payment of home health care services provided in accordance with Section 4600 that are not covered by a Medicare fee schedule and are not otherwise covered by the official medical fee schedule adopted pursuant to Section 5307.1. The schedule shall set forth fees and requirements for service providers, and shall be based on the maximum service hours and fees as set forth in regulations adopted pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code. No fees shall be provided for any services, including any services provided by a member of the employee's household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of injury. If appropriate, an attorney's fee for recovery of home health care fees under this section may be awarded in accordance with Section 4906 and any applicable rules or regulations.

Section 4603.2(b)(1) states that:

> Any provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician

> if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received. Nothing in this section shall prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600.

Sections 4600(h), 4603.2(b)(1), and 5307.8 were enacted by SB 863 [Stats. 2012, ch. 363, § 35, 36, 76] and, as explained below, apply to all requests for home health care services and for payment thereof where no final decision on the request had issued by January 1, 2013.

Section 4600(h) makes clear that home health care services are included in the definition of "medical treatment,"[8] but it also limits an employer's duty to provide that treatment by imposing two additional conditions which are part of an injured worker's burden of proof. The first condition requires that home health care services be prescribed by a physician, and an employer may become liable for home health care services provided 14 days prior to receipt of a prescription. The second condition requires that an employer's liability for home health care services is subject to either section 5307.1 or section 5307.8. Section 5307.1 applies where an official medical fee schedule or Medicare schedule covers the type of home health care services sought.[9] When the type of services sought is not covered by an official medical fee schedule or Medicare schedule, section 5307.8 applies.

---

[8] Section 4600(a), (h) [employer must provide an injured worker with all medical treatment reasonably required to "cure or relieve" the injured worker from "the effects of his or her injury"]; section 4600(b) [defining reasonably required treatment]; see *Henson v. Workmen's Comp. Appeals Bd.* (1972) 27 Cal.App.3d 452, 457 [37 Cal.Comp.Cases 564] [employer has affirmative statutory duty to provide medical treatment].

[9] Section 5307.1(a)(1) requires that an official medical fee schedule be adopted and that "[e]xcept for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems." Section 5307.1(a)(2)(C) provides that after January 1, 2014 and until new official medical fee schedules are adopted, "nonphysician practitioner services, including, but not limited to, nursing physician assistant, nurse practitioner, and physical therapist services shall be in accordance with the fee-related structure and rules of the Medicare payment system for. . . nonphysician practitioner services."

Here, the home health care services at issue were provided by applicant's spouse, and based on her testimony, it appears that the type of services she provided were not the type of services that are covered by an official medical fee schedule or a Medicare schedule. Thus, we will not address circumstances where section 5307.1 services are provided, except that we note that the prescription requirement and the duty to pay for services provided 14 days prior to receipt of a prescription also apply to section 5307.1 services. However, once the record is developed, it may be that there is evidence that applicant was actually provided the type of services that are covered by an official medical fee schedule or a Medicare schedule, and applicant would be entitled to pursue reimbursement as appropriate for those services.

Section 5307.8 requires adoption of a fee schedule based on regulations adopted under the Welfare and Institutions Code. To date, no schedule has been adopted. Consequently, in order to meet the burden on the issues of the number of hours and the rate of reimbursement an injured worker must submit substantial evidence of the reasonably required number of hours and a reasonable rate of reimbursement.[10] However, the two other provisions of section 5307.8 still apply. An injured worker must show that the home health care services at issue had not been "regularly performed in the same manner and to the same degree prior to the date of injury." An injured worker may seek reimbursement for home health care services and attorney's fees and/or an award of future medical care in the form of home health care services as part of an injured worker's case-in-chief.

II. HOLDINGS

A. Sections 4600(h), 4603.2(b)(1), and 5307.8 apply to requests for home health care services in all cases that are not final regardless of date of injury or dates of service.

"A fundamental rule of statutory construction is that a court should ascertain the intent of the Legislature so as to effectuate the purpose of the law." (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 387 [58 Cal.Comp.Cases 286] (*DuBois*); *Nickelsberg v. Workers' Comp. Appeals Bd.* (1991) 54 Cal.3d 288, 294 [56 Cal.Comp.Cases 476].) "In construing a statute, our first task is to look to the language of the statute itself. (Citation.) When the language is clear and there is no uncertainty as to the legislative intent, we look no further and simply enforce the statute according to its terms." (*DuBois, supra,* 5 Cal.4th at p. 387; accord, *Atlantic Richfield Co. v. Workers' Comp. Appeals Bd.* (*Arvizu*) (1982) 31 Cal.3d 715, 726 [47 Cal. Comp. Cases 500].)

Sections 4600(h), 4603.2(b)(1), and 5307.8 were enacted by SB 863, which became effective on January 1, 2013. Uncodified section 84 of SB 863 provides that: "This act shall apply to all pending

---

[10] Sections 3202.5, 5705; 5952(d); see e.g., *State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (*Sandhagen*) (2008) 44 Cal.4th 230, 242 [73 Cal.Comp.Cases 981] [injured worker bears the burden of proof to show that medical treatment is reasonably required].

Here, there is no evidence that defendant submitted applicant's request for home health care services to Utilization Review (UR). Therefore, we will not address circumstances where a request has been submitted to UR, and since no decision issued from UR, we will not address circumstances where Independent Medical Review (IMR) might apply. (See §§ 4610, 4610.5; see also § 4062.)

matters, regardless of date of injury, unless otherwise specified in this act, but shall not be a basis to rescind, alter, amend, or reopen any final award of workers' compensation benefits." Sections 4600(h), 4603.2(b)(1), and 5307.8 do not specify that they only apply to dates of injury on or after January 1, 2013. The language of section 84 of SB 863 is nearly identical to the language of uncodified section 47 of SB 899, which became effective in 2004. The appellate cases that interpreted section 47 found that the newly enacted and amended sections which were part of SB 899 were applicable to any pending case, except cases that were "final" subject only to the Appeals Board's continuing jurisdiction under sections 5803 and 5804. (E.g., *Sierra Pacific Industries v. Workers' Comp. Appeals Bd.* (*Chatham*) (2006) 140 Cal.App.4th 1498, 1506-1509 [71 Cal.Comp.Cases 714] [SB 899's amendment of section 4600(b) requiring application of the ACOEM guidelines to determine whether medical treatment was reasonably required was applicable to all pending cases regardless of date of injury]; *E & J Gallo Winery v. Workers' Comp. Appeals Bd.* (*Dykes*) (2005) 134 Cal.App.4th 1536, 1543 [70 Cal.Comp.Cases 1644] [apportionment provisions in SB 899's new sections 4663 and 4664 were applicable to all non-final cases regardless of date of injury].) Therefore, based on the nearly identical language in section 84 of SB 863, as of January 1, 2013, the provisions of sections 4600(h), 4603.2(b)(1), and 5307.8 became applicable to any pending case, except cases that were "final" subject only to the Appeals Board's continuing jurisdiction under sections 5803 and 5804.

This conclusion is also mandated by the well-established principle that the right to receive workers' compensation benefits is "wholly statutory." (*DuBois, supra,* 5 Cal.4th at p. 388;[11] *Beverly Hilton Hotel v. Workers' Comp. Appeals Bd.* (*Boganim*) (2009) 176 Cal.App.4th 1597, 1604 [74 Cal.Comp.Cases 927].) Furthermore, where a right is created solely by a statute, and the right has not

[11] California's workers' compensation system is founded upon, and circumscribed by, the state Constitution, article XIV, section 4. In *DuBois*, the Supreme Court stated that:

> "Pursuant to the 'plenary power' the Constitution has granted to the Legislature 'to create, and enforce a complete system of workers' compensation' (Cal. Const., art. XIV, § 4), the Legislature has created a statutory scheme requiring all employers to secure the payment of workers' compensation to injured workers, either by obtaining insurance coverage of their liability or by obtaining a certificate of consent to self-insure issued by the Director of Industrial Relations. (§ 3700 et seq.) The right to workers' compensation benefits is wholly statutory and is not derived from common law. (Citation.)"

been perfected by a final decision, the right is not vested but merely inchoate and may be modified or even entirely abolished by the Legislature at any time. (*Boganim*, 176 Cal.App.4th at pp. 1605-1607; *Graczyk v. Workers' Comp. Appeals Bd.* (1986) 184 Cal.App.3d 997, 1006–1007 [51 Cal.Comp.Cases 408]; see e.g., Gov. Code, § 9606.)

Finally, in *Valdez v. Workers' Comp. Appeals Bd.* (2013) 57 Cal.4th 1231, 1237, 1240 [78 Cal.Comp.Cases 1209], the Supreme Court discussed newly amended section 4605, and referred to newly amended sections 4061 and 4062 and newly enacted section 4603.2(a). Based on the language of section 84 of SB 863, the Supreme Court concluded that: "The changes made by Senate Bill 863 apply generally to proceedings that have not resulted in a final award." (57 Cal.4th at p. 1238.)

Thus, sections 4600(h), 4603.2(b)(1), and 5307.8 apply to any requests for home health care services or for payment thereof where no final decision on the request had issued before January 1, 2013.

B. The prescription required by section 4600(h) is either an oral referral, recommendation or order for home health care services for an injured worker communicated directly by a physician to an employer and/or its agent; or, a signed and dated written referral, recommendation or order by a physician for home health care services for an injured worker.

Section 4600(h) requires that home health care services be prescribed by a "physician" licensed pursuant to Business and Professions Code section 2000 et seq. Business and Professions Code section 2050 specifies that there is only one form of licensure for medical doctors "which shall be designated as [a] 'physician's and surgeon's certificate.'" Under Business and Professions Code section 4039, a "physician" "includes any person holding a valid and unrevoked physician's and surgeon's certificate or certificate to practice medicine and surgery, issued by the Medical Board of California or the Osteopathic Medical Board of California." In sum, for the purposes of home health care services, the prescription must be by a practitioner who is licensed by the Medical Board or Osteopathic Medical Board.[12]

[12] Section 3209.3(a) defines "physicians" as "physicians holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners." Section 4600(h) only allows prescriptions for home health care services by a licensed physician or licensed osteopath, so that a prescription by any other practitioner as defined by section 3209.3(a) would not meet the requirements of section 4600(h) unless adopted and incorporated by a licensed physician or licensed osteopath.

Section 4600(h) and the related statutes do not define the meaning of "prescribed" and the Labor Code does not contain a definition of a "prescription." Accordingly, since the applicable definition of a physician is contained in the Business and Professions Code, we consider the definition of a prescription in the Business and Professions Code.[13] Business and Professions Code section 4040 states in pertinent part that: "(a) 'Prescription' means an oral [or] written . . . order that is ***both*** of the following: (1) ***Given individually for the person*** or persons for whom ordered that includes all of the following: (A) The name or names and address of the patient or patients; … (C) The date of issue; (D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification . . . (F) If in writing, signed by the prescriber issuing the order . . . [and] (2) ***Issued by a physician*** . . . " (Italics and bolding added.)[14] Based on this definition, in the context of home health care services a prescription is issued by a physician (i.e., an M.D. or a D.O.) and is an oral order for a patient or, a written order identifying the patient, with the date, the name and address of the prescriber, and the signature of the physician.

The definition does not require that a prescription be labelled or written on a particular form and does not require a detailed description of the recommended services. But, by itself, a prescription is not "proof" of what are reasonable and necessary home health care services. Injured workers bear the burden to prove that the services are reasonably required. Injured workers and their physicians are required to comply with the applicable rules and statutes when seeking services. Hence, an oral or written communication which meets the minimum requirements is sufficient to meet the condition in section

---

[13] The only other definition of prescription is found in the Health and Safety Code. Health and Safety Code section 110010 states that:

> "Prescription" means an oral order given individually for the patient for whom prescribed directly from the prescriber to the furnisher or indirectly by means of a written order signed by the prescriber that bears the name and address of the prescriber, the license classification of the prescriber, the name and address of the patient, the name and quantity of drug or device prescribed, the directions for use, and the date of issue.

[14] Business and Professions Code section 4040 contains a number of provisions that apply to drugs or devices, and for clarity, we have omitted all of those portions. Specifically, "directions for use" or "the condition or purpose" for the order is only required to be included in the prescription when it is for drugs or a device. (See Bus. & Prof. Code, § 4040(a)(1)(B)(E).) This definition also allows prescriptions by providers other than physicians, and for clarity, we have omitted those references.

4600(h) that home health care services be prescribed. *Thus, we hold that the prescription required by section 4600(h) is either an oral referral, recommendation or order for home health care services for an injured worker communicated directly by a physician to an employer and/or its agent; or, a signed and dated written referral, recommendation or order by a physician for home health care services for an injured worker.*

When seeking home health care services, an injured worker must show that a prescription, as defined above, exists. This prescription requirement is a limit on the employer's duty to provide medical treatment. Separately, an injured worker must prove that the prescription was received by the employer and the date on which it was received. This receipt requirement narrows an employer's duty to pay for medical treatment because an employer's liability is limited to 14 days before the date that the prescription was received. Liability is not based on the date that the need for services may have begun.

Section 4600(h) does not specify *how* an employer must receive the prescription before it may become liable for care and does not require that the prescription be submitted by an injured worker. With respect to an oral prescription, in order for an employer to "receive" the communication, it can only be made directly to the employer or the employer's agent. In contrast, while a written prescription may be received by an employer directly from a physician, so long as it meets the definition of a prescription, it may also be received from another source, including from the injured worker, an injured worker's agent, a third person, or another provider. For example, an employer may "receive a prescription" in the form of a request for authorization by a physician, a medical report, or a medical record.[15]

---

[15] AD Rule 9792.6(q) states that:

> "Request for authorization" means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization. (Cal. Code Regs., tit. 8, § 9792.6(q).)

WCAB Rule 10606(b) sets forth the requirements for a "medical report." (Cal. Code Regs., tit. 8, § 10606(b).)

Under some circumstances, an employer may receive an oral communication or a document which is ambiguous, so that it is not clear whether the oral communication or the document was actually a "prescription" sufficient to trigger the liability period. In that case, or under other circumstances when an employer receives other notice that home health care services may be needed or are being provided, an employer has a duty under section 4600 to investigate. (See *Braewood Convalescent Hosp. v. Workers' Comp. Appeals Bd.* (*Bolton*) (1983) 34 Cal.3d 159, 165 [48 Cal.Comp.Cases 566].) In addition to the judicially announced obligation to do more than passively sit by, an employer also has a regulatory duty to conduct a reasonable and good faith investigation to determine whether benefits are due. (See Cal. Code Regs., tit. 8, § 10109.)

C. Under section 4600(h), home health care services are subject to either section 5307.1 or section 5307.8. Section 5307.1 applies where an official medical fee schedule or Medicare schedule covers the type of home health care services sought. Otherwise, section 5307.8 applies.

The second condition in section 4600(h) provides that an employer's liability for home health care services is subject to section 5307.1 or section 5307.8. As set forth above, where no official medical fee schedule or Medicare schedule covers the type of services sought, then section 5307.8 applies. Section 5307.8 contains three provisions, which by definition only apply to that type of services and those three provisions are part of an injured worker's burden of proof.

The first provision of section 5307.8 requires that "the administrative director shall adopt … a schedule for payment of home health care services" and that this schedule, when adopted, "shall be based on the maximum hours and fees as set forth in regulations adopted pursuant to . . . [s]ection 12300 [et seq.] of the Welfare and Institutions Code" relating to In-Home Supportive Services (IHSS). As of the date of this opinion, no schedule has been adopted. (See AD Rule 9789.90, which is reserved for home health care services. (Cal. Code Regs., tit. 8, § 9789.90.)) Although section 5307.8 requires a schedule based on those IHSS regulations, neither the provisions of Welfare and Institutions Code section 12300 et seq. nor the IHSS regulations govern home health care services under section 4600(h).[16] As a result,

---

[16] For example, Welfare and Institutions Code section 12300(h)(3), which provides that payment is limited to 283 hours per month or up to 9 hours per day does not apply to home health care services under section 4600(h).

an injured worker continues to bear the burden to demonstrate a reasonable hourly rate for the type of services provided and the number of reasonably required hours based on substantial evidence.

The second provision states that: "No fees shall be provided for any services, *including* any services provided by a member of the employee's household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of injury." (Italics added.) Of note, because section 5307.8 uses the phrase "including" with respect to services provided by a household member, this provision applies to all previously provided services and not just those that were provided by a household member. (*Flanagan v. Flanagan* (2002) 27 Cal.4th 766, 774 [the word "includes" is "ordinarily a term of enlargement rather than limitation"]; accord, *Kight v. CashCall, Inc.* (2011) 200 Cal.App.4th 1377, 1391.)

The third provision allows "an attorney's fee for recovery of home health care fees *under this section* . . . in accordance with [s]ection 4906 and any applicable rules or regulations." (Italics added.) Section 4906(a) refers to a lien under section 4903(a), which is a lien against an injured worker's compensation by an applicant's attorney for attorney's fees, and section 4906(b) refers to attorney's fees from "an employee." Section 4906(d) states that: "In establishing a reasonable attorney's fee, consideration shall be given to the responsibility assumed by the attorney, the care exercised in representing the applicant, the time involved, and the results obtained." (See also Cal. Code Regs., tit. 8, §§ 10775, 10776, 10778.) Hence, a reasonable attorney's fee based on the recovery of section 5307.8 home health care services may be sought by an applicant's attorney.

Like other forms of medical treatment, nothing in sections 4600(h) and 5307.8 requires an injured worker to actually incur the cost of services before seeking home health care services.[17] Neither section identifies the payment recipient or requires that the recipient be an injured worker or a provider, although by allowing attorney's fees, section 5307.8 implies that reimbursement for this type of services is to an injured worker. Consequently, an injured worker may seek reimbursement for home health care services

[17] See section 4600(a) [employer is liable for "reasonable expense incurred by or on behalf of the employee" when there is a neglect or refusal to provide reasonably required medical treatment].

or an award of future medical treatment in the form of home health care services for an injured worker or a provider, and reasonable attorney's fees, in the case-in-chief.

In its Petition, defendant contended that an award of home health care services should be denied because applicant's spouse did not submit an itemization of services pursuant to section 4603.2(b)(1). Under section 4603.2(b)(1), a provider must submit documentation to an employer before an employer is required to pay. This includes an itemization of services and charges, copies of all reports showing services performed, a prescription or referral by the primary treating physician, and any evidence of authorization.[18] However, as discussed above, section 5307.8 requires an injured worker to produce evidence describing the hours of services required and provided, evidence explaining which services may have been provided before an industrial injury, and evidence of a reasonable hourly rate. While this evidence may also be considered an itemization of services and charges, the converse is not true. Section 4603.2(b)(1) is not part of an injured worker's burden of proof under sections 4600(h) and 5307.8. Instead, section 4603.2(b)(1) concerns payment.

Section 4603.2(b)(1) does not specify when the itemized description and billing must be submitted and no other statute refers to an itemized description and billing with respect to section 5307.8 services. Accordingly, setting aside any other statutory time lines, documentation under section 4603.2(b)(1) may be submitted to an employer as appropriate. Moreover, section 4603.2(b)(1) also states that: "Nothing in this section shall prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600." Thus, while a provider of home health care services must comply with section 4603.2(b)(1) in order to be paid, an employer may also choose to pay for home health care services without the required documentation, including a "prescription."

Of note, under section 4603.2(b)(1), the prescription requirement is met by submitting a prescription by a primary treating physician when a primary treating physician provides the services, or a

[18] In contrast, section 4603.2(b)(2) sets forth a procedure for payment and provides for various notifications by the employer and time limits for payment. Since section 4603.2(b)(2) specifically refers to section 5307.1, and not to section 5307.8, the guidelines for payment by an employer under section 4603.2(b)(2) do not apply to providers under section 5307.8.

referral by a primary treating physician if another person provides the services. This means that even if a prescription from another physician meets the requirements of section 4600(h), section 4603.2(b)(1) requires a referral by a primary treating physician. At the same time, a report or a request for authorization that is signed by a primary treating physician who is a physician as defined above under section 4600(h) can be a prescription under both section 4600(h) and section 4603.2(b)(1). Additionally, section 4603.2(b)(1) requires "copies of reports" and "any evidence of" authorization. Consequently, section 4603.2(b)(1) does not impose a separate reporting requirement or a separate procedure for obtaining authorization, but merely shifts the duty to the provider who is seeking payment to include those documents as appropriate.

III. APPLICANT'S CASE

Dr. Gordon's September 17, 2012 and November 5, 2012 reports reflect that applicant sustained a severe injury to his dominant hand when it was crushed in a power press machine resulting in its "near-amputation." Dr. Gordon's September 17, 2012 report states that applicant had five surgeries after his injury of July 11, 2011 and that more than one year later applicant had essentially lost all use of his hand and continued to have "extremely severe pain when trying to move the hand in any way at all." Dr. Lee's November 11, 2011 note is evidence of his opinion that applicant needed assistance from his spouse. Moreover, applicant's spouse's unrebutted and unimpeached trial testimony established that she performed home health care services for applicant. Thus, with respect to defendant's first contention that applicant's award of home health care services was not supported by substantial medical evidence, without considering any other issues, the WCJ could properly find that the evidence before him showed that applicant was and is in need of home health care services.

However, as set forth above, in order to obtain an award of home health care services, section 4600(h) requires applicant to show that he had a prescription, that it was received by defendant, and that he met the requirements of section 5307.8. Section 5307.8 requires an injured worker to produce evidence describing the hours of services required and provided, evidence explaining which services may have been provided before an industrial injury, and evidence of a reasonable hourly rate.

With respect to the requirement of a prescription, the November 11, 2011 note from Dr. Lee states that applicant has been under the care of Dr. Lee "for severe injury to his RT. hand since 7-11-11 at which time he has needed constant care from his wife Adriana Bayona." The note is dated, is in writing and is signed. It identifies applicant and his treating physician, and it states that applicant needs care by his spouse. We conclude that this note is a prescription for home health care services within the meaning of section 4600(h).

The letter from applicant's counsel to defendant's counsel reflects that Dr. Lee's November 11, 2011 prescription was sent to defendant by applicant on November 28, 2011. In that letter, applicant's counsel stated: "Please allow this letter to serve as my formal request that you authorize the applicant's wife, Adrianna Bayona to provide in-home [sic] for the applicant," and defendant admitted receipt of the letter and the attachment. Thus, even though the date of receipt is not clear and defendant disputed that it was a "prescription," defendant "received a prescription" as required by section 4600(h) and at a minimum, defendant's potential liability period began 14 days prior to the date it received the letter and the prescription.

Dr. Lee's prescription refers to the period from the date of applicant's injury to November 11, 2011. Applicant suffered a severe injury, and it appears that he was in need of home health care services and that his spouse was caring for him from the time of his release from the hospital, if not before. Specifically, applicant's spouse testified that she was "required to spend all day long" with applicant following his release from the hospital, that she discussed her care of his hand after it became infected in September 2011 with Dr. Lee, and that Dr. Lee told her that she "had to clean the applicant up as they could not get a nurse." It may be that defendant received medical records from the hospital from before November 11, 2011 containing a referral or recommendation for home health care services or providing notice of applicant's need for home health care services. Applicant's spouse's testimony suggests that Dr. Lee may have communicated with defendant about applicant's need for home health services and at a minimum, raises an inference that defendant may have received notice of the need for home health care services such that it should have investigated. Thus, we are unable to determine based on the evidence in the record before us whether the liability period may have begun at an earlier time.

Here, the WCJ awarded payment to applicant's spouse at her previous earnings rate based on what he assumed were the number of hours recommended by Dr. Lee and Dr. Gordon retroactive to August 3, 2011. In addition to the issues raised by the prescription requirement as set forth above, the record lacks detailed evidence of what services were actually needed and what services applicant's spouse actually performed before and after the injury. Moreover, any award of reimbursement would be based on an appropriate rate for a similar caregiver and would not be based on a spouse's loss of earnings from previous employment. Thus, we must rescind the Findings and Award.

The Appeals Board has the discretionary authority to develop the record when the record does not contain substantial evidence or when appropriate to provide due process or fully adjudicate the issues. (§§ 5701, 5906; *Tyler v. Workers' Comp. Appeals Bd.* (1997) 56 Cal.App.4th 389, 394 [62 Cal.Comp.Cases 924] ["The principle of allowing full development of the evidentiary record to enable a complete adjudication of the issues is consistent with due process in connection with workers' compensation claims."]; see *McClune v. Workers' Comp. Appeals Bd.* (1998) 62 Cal.App.4th 1117 [63 Cal.Comp.Cases 261].) For the reasons explained above, we conclude that the record requires further development.

Thus, as our decision after reconsideration, we rescind the Findings and Award and return the matter to the WCJ for further development of the record consistent with this opinion and a new decision. When the WCJ issues a new decision, any aggrieved party may timely seek reconsideration.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board (En Banc) that the Opinion and Order Granting Petition for Reconsideration and Decision After Reconsideration issued by an Appeals Board panel on August 12, 2013 is **RESCINDED**.

\ \ \

\ \ \

\ \ \

\ \ \

\ \ \

IT IS FURTHER ORDERED that the Findings and Award issued by the workers' compensation administrative law judge on May 30, 2013 is **RESCINDED** and the matter is **RETURNED** to the workers' compensation administrative law judge for further proceedings consistent with this opinion and a new decision from which any aggrieved party may timely seek reconsideration.

WORKERS' COMPENSATION APPEALS BOARD (EN BANC)

/s/ Ronnie G. Caplane
RONNIE G. CAPLANE, Chairwoman

/s/ Frank M. Brass
FRANK M. BRASS, Commissioner

/s/ Deidra E. Lowe
DEIDRA E. LOWE, Commissioner

/s/ Marguerite Sweeney
MARGUERITE SWEENEY, Commissioner

/s/ Katherine A. Zalewski
KATHERINE A. ZALEWSKI, Commissioner

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

06/12/2014

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

ROQUE NERI HERNANDEZ
RANCANO & RANCANO
SAMUELSEN, GONZALEZ, VALENZUELA & BROWN, LLP, ATTN: BRIAN ISHIMOTO
ADELSON, TESTAN, BRUNDO, NOVELL & JIMINEZ

AS/jp