WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

TADESSE SENBETU, *Applicant*

vs.

COUNTY OF LOS ANGELES;
legally uninsured and administered by SEDGWICK CLAIMS MANAGEMENT, INC.,
Defendants

Adjudication Number: ADJ8539700
Los Angeles District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

We have considered the allegations of the Petition for Reconsideration and the contents of the Report and the Opinion on Decision of the workers' compensation administrative law judge (WCJ) with respect thereto. Based on our review of the record, and for the reasons stated in the WCJ's Report and the Opinion on Decision, both of which we adopt and incorporate, and for the reasons discussed below, we will deny reconsideration.

I.

Preliminarily, we note that former Labor Code[1] section 5909 provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.) Effective July 2, 2024, section 5909 was amended to state in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.

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

> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

Under section 5909(a), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected in Events in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on August 6, 2025 and 60 days from the date of transmission is Sunday, October 5, 2025. The next business day that is 60 days from the date of transmission is Monday, October 6, 2025. (See Cal. Code Regs., tit. 8, § 10600(b).)[2] This decision is issued by or on Monday, October 6, 2025, so that we have timely acted on the petition as required by section 5909(a).

Section 5909(b)(1) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to act on a petition. Section 5909(b)(2) provides that service of the Report and Recommendation shall be notice of transmission.

Here, according to the proof of service for the Report and Recommendation by the workers' compensation administrative law judge, the Report was served on August 6, 2025, and the case was transmitted to the Appeals Board on August 6, 2025. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that the parties were provided with the notice of transmission required by section 5909(b)(1) because service of the Report in compliance with section 5909(b)(2) provided them with actual notice as to the commencement of the 60-day period on August 6, 2025.

[2] WCAB Rule 10600(b) (Cal. Code Regs., tit. 8, § 10600(b)) states that:

> Unless otherwise provided by law, if the last day for exercising or performing any right or duty to act or respond falls on a weekend, or on a holiday for which the offices of the Workers' Compensation Appeals Board are closed, the act or response may be performed or exercised upon the next business day.

II.

Pursuant to section 5705, "The burden of proof rests upon the party or lien claimant holding the affirmative of the issue." (Lab. Code, § 5705.) A lien claimant has the burden of proving all elements necessary to establish the validity of its lien. Section 3202.5 states that, "All parties and lien claimants shall meet the evidentiary burden of proof on all issues by a preponderance of the evidence." (Lab. Code, § 3202.5; *Boehm & Associates v. Workers' Comp. Appeals Bd. (Brower)* (2003) 108 Cal.App.4th 137, 150 [68 Cal.Comp.Cases 548, 557.) A lien claimant treating physician's burden of proof includes the burden of showing that he or she provided medical treatment "reasonably required to cure or relieve" the injured worker from the effects of an industrial injury. (Lab. Code, § 4600(a); *Williams v. Industrial Acc. Com*. (1966) 64 Cal.2d 618 [31 Cal.Comp.Cases 186]; *Beverly Hills Multispecialty Group, Inc. v. Workers' Comp. Appeals Bd.* (1994) 26 Cal.App.4th 789 [59 Cal.Comp.Cases 461]; *Workmen's Comp. Appeals Bd. v. Small Claims Court (Shans)* (1973) 35 Cal.App.3d 643 [38 Cal.Comp.Cases 748].) Where a lien claimant, rather than the injured worker, litigates the issue of entitlement to payment for industrially-related medical treatment, the lien claimant stands in the shoes of the injured worker and the lien claimant must establish injury by preponderance of evidence. (*Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (Martin)* (1985) 39 Cal.3d 57, 67 [50 Cal.Comp.Cases 411]; *Kunz, supra*, 67 Cal.Comp.CasAyes at p. 1592.)

It is well established that decisions by 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, supra*; *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 mind 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], emphasis removed and citations omitted.) To constitute substantial evidence "… a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions." (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 621 (Appeals Board en banc).)

For the reasons stated in the WCJ's Report and Opinion on Decision, we agree that lien claimants did not meet their burden of proof.

For the foregoing reasons,

IT IS ORDERED that the Petition for Reconsideration is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE A. ZALEWSKI, CHAIR

I CONCUR,

/s/ CRAIG L. SNELLINGS, COMMISSIONER

/s/ LISA A. SUSSMAN, DEPUTY COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

OCTOBER 6, 2025

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

ZA MANAGEMENT
COMPREHENSIVE OUTPATIENT SURGERY CENTER
CALIFORNIA URGENT CARE CENTER
TECHNICAL SURGERY SUPPORT
MARINA RUSSMAN, M.D., DE LA LOZA

PAG/bp

I certify that I affixed the official seal of the Workers' Compensation Appeals Board to this original decision on this date.
BP

REPORT AND RECOMMENDATION ON PETITION FOR RECONSIDERATION

I
INTRODUCTION

Tadesse Senbetu, a 53-year old CNA for County of Los Angeles, filed an Application for Adjudication on 9/19/12 alleging that during the period commencing 1/1/10 through 9/19/12, he sustained injury arising out of and occurring in the course of employment to his back, shoulders, neck, arm, hand, legs, knees, head, and psyche, as a result of repetitive activities. The claim was accepted by the employer.

Lien Claimants (hereinafter Petitioners) Comprehensive Outpatient Surgery Center, California Urgent Care Center, Technical Surgery Support, and Marina Russman M.D. have filed a timely, verified Petition for Reconsideration of the Findings and Orders dated 7/8/25 that does not specifically allege any statutory grounds.

Petitioners contend that the Court erred in determining that:

1. Petitioner did not meet its burden to prove that medical treatment services consisting of, or related to, the epidural steroid injections provided in this case were reasonably required to cure or relieve from the effects of the industrial injury herein, and;
2. The value of the reasonably required medical treatment services was equal to the sum of $1,353.92.

II
FACTS

Applicant began treating with Dr. Shah on 9/27/12 (LC exhibit 39). A progress report from Dr. Shah dated 6/3/13 reflects that a pain management consult was recommended (LC exhibit 38). Applicant began treating with Petitioner Russman for pain management on 6/12/13 (LC exhibit 35). Petitioner Russman recommended Applicant underdo a lumbar epidural steroid injection since conservative treatment had not been successful as well as the existence of a focal dermatomal radicular pain distribution. It was also opined that Applicant should have internal medicine clearance and a psychological evaluation before proceeding with the injection. Authorization was requested for the procedure on 6/19/13 (LC exhibit 17). That request was not placed through Utilization Review. Despite no internal medicine clearance and no psychological evaluation, Applicant had the procedure performed on 6/27/13 (LC exhibit 57). Petitioner Comprehensive Outpatient Surgery Center provided the facility (LC exhibit 57). Petitioner Technical Surgery Support presumably provided imaging support (LC exhibit 3). Petitioner California Urgent Care Center presumably provided anesthesiology services (LC exhibit 1). Petitioner Russman performed the injections.

Applicant had subsequent injections on 8/1/13, 9/10/13, 10/10/13, 11/14/13, 12/23/13, and 1/23/14 (LC exhibits 51-56) that involved the services of all Petitioners. Petitioner Russman requested authorization for each procedure (LC exhibits 11-16, and in all but one instance, Defendant did not place the request through Utilization Review. The only request placed through Utilization Review by Defendant was dated 7/24/13 and denied on 8/1/13 (Defense A). The medical report supporting the denial was not offered into evidence.

The lien issues were tried and submitted on 5/13/25. No documentation regarding the MTUS was offered into evidence. The Court issued Findings and Orders on 7/8/25 wherein the

liens of Petitioners Comprehensive Outpatient Surgery Center, California Urgent Care Center, Technical Surgery Support were disallowed in their entirety. The Court also determined that the services of Petitioner Marina Russman that were not related to the injections, were reasonably required. Payment of those services were awarded equal to the sum of $1,353.92 less credit to Defendant for prior payments equal to the sum of $232.98 based on Defendant's bill review dated 10/5/18 (Defense exhibit B).

III
DISCUSSION

MEDICAL NECESSITY

Pursuant to Labor Code section 4600(a), the employer shall provide medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the worker's injury. Reasonably required medical treatment is defined in section 4600(b) as treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27, also known at the Medical Treatment Utilization Schedule (hereinafter MTUS). The California Supreme Court decision in SCIF v. WCAB *(Sandhagen)* (2008) 73 CCC 981 held that a party could not utilize med-legal procedures to dispute a request for medical treatment, but that the parties must utilize Utilization Review in accordance with LC section 4610. But in cases where Defendant does not place a Request for Authorization through Utilization Review, the burden of proof regarding the medical necessity of the treatment still falls to Applicant (Dubon v. World Restoration, Inc. (2014) 79 CCC 1298, 1312 (appeals board *en banc*).). It is well settled that the Lien Claimant steps into the shoes of the Applicant when prosecuting their lien.

Petitioner seemingly argues that the Court stated that Petitioners did not submit medical evidence to support the medical treatment provided. However, that is not what the Court stated. In the Opinion on Decision the Court held that there was no evidence to support that the services provided were consistent with the Medical Treatment Utilization Schedule (MTUS). Petitioner has not made any argument or pointed to any evidence in the record to refute that point. The medical evidence in the case does not discuss, reference, or otherwise correlate the medical treatment requested and provided with the MTUS. As such, Petitioners (other than the services specified as reasonable by Petitioner Russman) did not meet their burden to prove that medical treatment services consisting of, or related to, the epidural steroid injections provided in this case were reasonably required to cure or relieve from the effects of the industrial injury in this case.

Petitioner also seemingly argues that it is Defendant that has the burden to prove the medical necessity of the services provided. Clearly the case of Dubon refutes that argument.

VALUE

The Court used Defendant's bill review dated 10/5/18 to calculate the reasonable value of the medically necessary services. Those services included exams, reports, blood tests, and pharmacological management. The total sum per that bill review was $1353.92. Petitioner somehow arrived at a sum equal to $6,761.48 without pointing to any aspect of the bill review to support such figure. In looking at the bill review, the following breakdown was used by the Court:

1. 11 reports at $9.94 for a total of $109.34;

2. 5 reports (after 2014) at $10.12 for a total of $50.60;
3. 5 evaluation and management services at $76.13 for a total of $380.65;
4. The initial date of service of 6/12/23 (including blood tests) totaling $341.72;
5. The second date of service of 6/13/23 totaling $277.21;
6. 2 prolonged office services at $97.20 totaling $194.40.
7. The bill review contained no allowances for "pharmacological management."

Grand total of the above figures equals the sum of $1353.92. This is what was ordered for Defendant to pay, less credit for payments made.

IV
RECOMMENDATION

For the foregoing reasons, the undersigned WCALJ recommends that the Petition for Reconsideration be **DENIED**.

DATE: 8/5/25

Jeffrey Morgan
WORKERS' COMPENSATION
JUDGE

OPINION ON DECISION

MEDICAL NECESSITY/ CALIFORNIA URGENT CARE/TECHNICAL SURGERY SUPPORT/ COMPREHENSIVE OUTPATIENT SURGERY CENTER

Pursuant to Labor Code section 4600(a), the employer shall provide medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the worker's injury. Reasonably required medical treatment is defined in section 4600(b) as treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27, also known at the Medical Treatment Utilization Schedule (hereinafter MTUS). The California Supreme Court decision in SCIF v. WCAB *(Sandhagen)* (2008) 73 CCC 981 held that a party could not utilize med-legal procedures to dispute a request for medical treatment, but that the parties must utilize Utilization Review in accordance with LC section 4610. But in cases where Defendant does not place a Request for Authorization through Utilization Review, the burden of proof regarding the medical necessity of the treatment still falls to Applicant (Dubon v. World Restoration, Inc. (2014) 79 CCC 1298, 1312 (appeals board *en banc*). It is well settled that the Lien Claimant steps into the shoes of the Applicant when prosecuting their lien.

The medical treatment services provided by the above referenced providers all pertain to seven epidural steroid injections administered to Applicant during the period commencing 6/27/13 through 1/23/14. Although there are numerous Requests for Authorization for these services, only one, dated 7/24/13, was placed through Utilization Review. That request was denied, but the report providing the medical explanation is not in evidence. Since there are no Utilization Review reports in evidence pertaining to these services, Lien Claimant has the burden under Dubon to prove that the services consistent with the MTUS.

Here, no such evidence was provided. No citations to the MTUS were made by Dr. Russman in attempting to justify the medical necessity of any of the lumbar injections and no other proof of MTUS requirements were placed into evidence. As such, Lien Claimants failed to meet their burden to prove the medical necessity of the services provided.

ENTITLEMENT TO TREATMENT EXPENSE/MEDICAL NECESESSITY/MOBILE RADIOLOGICAL AND ANESTHESIA

Lien Claimant has the burden to prove that it actually provided the services reflected on its bill. There is no documentation of any procedure requiring anesthesia taking place on 10/6/15. As such, that date of service is disallowed. As for the 4/12/16 date of service, there is no evidence that authorization was requested for the underlying course of medical treatment, nor is there any evidence of consistency with the MTUS. As such, Lien Claimant did not meet its burden to prove medical necessity of the /12/16 dated of service.

MEDICAL NECESSITY/MARINA RUSSMAN

As already covered, none of the epidural steroid injections or other associated procedures were proven to be consistent with the MTUS. The remainder of the services provided by Dr. Russman consisting of office visits, reports, and blood tests are deemed reasonably required to cure or relieve from the effects of the industrial injury.

VALUE/MARINA RUSSMAN

Based on Defendant's bill review dated 10/5/18, it is found that the reasonable value of Lien Claimant's medically necessary services is $1,353.92. Defendant is entitled to credit for sums previously paid equal to the sum of $232.98.

PENALTY AND INTEREST/MARINA RUSSMAN

The bills and reports for dates of service 2/10/14 and 4/14/14 were served on TriStar, which was the claims administrator at the time, on 5/20/14 and 6/17/14 respectively. Defendant did not make payment relative to those dates of service until 2/4/16. Thus, in accordance with Labor Code section 4603.2(b)(2), penalty and interest is owed by defendant regarding the allowed charges for those dates ($10.12 and $107.32 respectively). Lien Claimant also served their bills and reports on the claims administrator relative to the remainder of the allowed charges, but no payment was made. Thus, penalty and interest is also owed relative to those charges in accordance with Labor Code section 4603.2(b)(2). The exact amount of penalty and interest is to be adjusted by the parties with jurisdiction reserved.

DATE: 7/8/25

Jeffrey Morgan
WORKERS' COMPENSATION
JUDGE