WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

JOHN ENGLER, *Applicant*

vs.

WALGREENS COMPANY;
AMERICAN ZURICH INSURANCE COMPANY,
administered by SEDGWICK CMS, *Defendants*

Adjudication Number: ADJ2012962
San Bernardino District Office

OPINION AND ORDER GRANTING PETITION FOR RECONSIDERATION AND DECISION AFTER RECONSIDERATION

Lien claimants Comprehensive Outpatient Surgery Center (COSC) and California Urgent Care Center (CUCC) jointly seek reconsideration of the September 26, 2024 Findings and Order issued by the workers' compensation administrative law judge (WCJ). Therein, the WCJ found that applicant "sustained injury on [January 15, 2008] to the head, hernia, back, hips, foot, psyche and lumbar spine, but did NOT sustain injury to the thoracic spine, cervical spine or to the upper extremities;" that "[CUCC], is entitled to reimbursement for anesthesia services for ***no more than three*** lumbar spine procedures … but further development of the record is required to determine the OMFS reasonable charges for such service;" that "[COSC], is entitled to reimbursement for ***no more than three*** lumbar spine procedures …, but further development of the record is required to determine the OMFS reasonable charges for such services;" and that "lien claimant, Mumtaz Ali, M.D., ***may be entitled*** to reimbursement for treatment charges once further development of the record has been accomplished to determine what services he provided were related to the thoracic spine (non-industrial and noncompensable) and what services he provided were related to the lumbar spine (industrial) and comply with reasonableness standards." (Emphasis added.)

Lien claimants contend that the WCJ erred in finding the opinion of James Michael Fait, M.D., to be substantial medical evidence, that lien claimants should not be held accountable when

parties at the time of submitting evidence to the panel qualified medical evaluator (PQME) did not incorporate the documented reporting by other reporting doctors Higashi and Williams, that the reasonable value of six dates of pain management services, consistent with the WCJ's analysis, totals $44,715.00; and that defendant failed to timely respond to requests for authorization.

Defendant did not file an answer. The WCJ issued a Report and Recommendation on Petition for Reconsideration recommending that we deny reconsideration.

Based on our review of the record and for the reasons discussed below, we will grant reconsideration, rescind the WCJ's decision, and return this matter to the trial level.

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.
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> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.
>
> (§ 5909.)

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 November 5, 2024, and 60 days from the date of transmission is Saturday, January 4, 2025, which by operation

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

of law means that this decision is due by Monday, January 6, 2025. (Cal. Code Regs., tit. 8, § 10600.) This decision is issued by or on January 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.

According to the proof of service for the Report and Recommendation by the WCJ, the Report was served on November 5, 2024, and the case was transmitted to the Appeals Board on November 5, 2024. 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 November 5, 2024.

II.

The WCJ provided the following statement of facts in the Report:

> The underlying case involved a retail assistant manager, John Engler, who was employed by Walgreens Company on January 15, 2008, who sustained injury arising out of and in the course of employment to his head, hernia, back, hips, foot, psyche and lumbar spine pursuant to the Stipulated Award that issued 11/16/2023, resulting in a 40% permanent disability rating after apportionment.
>
> In the decision complained of, pertaining to the issues raised on reconsideration, the undersigned Workers' Compensation Administrative Law Judge found as follows:
>
> > "This matter was submitted on the record presented at trial without testimony. None of the lien claimants called applicant to testify as to the parts of body injured in the 1/15/2008 incident. The only medical reporting offered in evidence that provides a clear picture of mechanism of injury based upon a history taken from the patient as well as a thorough review of medical records, is the reporting of the Panel QME, James Michael Fait, M.D., who rendered a report of the 12/15/2016 examination that was executed by the doctor on 1/9/2017. I found this report to be persuasive, credible and substantial medical evidence. As is discussed in detail below,

Dr. Fait found orthopedic injury ONLY to the lumbar spine and right hip and did not find a cumulative trauma injury and did not find injury to the applicant's cervical spine, upper extremities or to the thoracic spine. Insofar as the case-in-chief resolved via Stipulations with Request for Award and Award that issued on 11/16/2023 and the parties further stipulated at the time of this trial that applicant sustained injury arising out of and in the course of employment to his head, hernia, back, hips, foot, psyche and lumbar spine, I find those parts of body to be the ONLY parts of body injured. There was no error for the failure to include thoracic spine insofar as Dr. Fait very specifically found that applicant had not sustained injury to that part of body, and further because there was no other persuasive, credible or substantial medical evidence or testimony to the contrary.

Medical Treatment

Injury AOE/COE was initially denied in this matter with defendant claiming that applicant "staged" his asserted injury. Upon limited issue AOE/COE trial, this was found not to be the case by the undersigned WCALJ, who found that applicant did sustain an injury arising out of and in the course of employment in her Findings of Fact and Opinion on Decision of 9/8/2009. However, that determination did not specify what part or parts of body were injured in the fall, as those issues were bifurcated and deferred by agreement of the parties. This opinion was upheld by the WCAB on 10/28/2009 after the filing of a Petition for Reconsideration.

The issue of what parts of body were injured in the 1/15/2008 incident as well as whether a CT injury had been sustained was submitted to Panel QME, James Michael Fait, M.D., who rendered a report of the 12/15/2016 examination that was executed by the doctor on 1/9/2017. Dr. Fait determined that applicant had reached a point of maximal medical improvement at the time of his evaluation, but also noted that Dr. Steiger had declared applicant "permanent and stationary" as of 8/23/2008. Dr. Fait found specific orthopedic injury ONLY to the lumbar spine and right hip, and specifically did not find injury to the cervical spine, bilateral upper extremities or to the thoracic spine and did not find there to be any cumulative trauma injury.

Dr. Fait was abundantly clear in his report that future medical care included access to oral anti-inflammatory medications, medications to protect the gastric mucosa, medications to alleviate muscular spasm and medications for the treatment of chronic neuropathic pain (i.e. Lyrica or Neurontin), as well as brief courses of physical therapy, chiropractic treatment and/or acupuncture would be appropriate for flare ups of lumbar spine, which would be anticipated to be one or two flare ups per calendar

year. He strongly recommended that applicant be followed by a pain management specialist, given the heavy use of oral narcotics. He also recommended detoxification and weaning off of narcotic pain medications. As to the right hip, Dr. Fait recommended access to orthopedic specialist at least every one to two years for surveillance x-rays to keep an eye on the hip prosthesis. Dr. Fait was very clear that he did not feel that additional treatment in the form of epidural injections or facet injections would be helpful. He did not believe applicant was a surgical candidate for any spinal fusion.

Dr. Fait did make specific comments on the medical treatment applicant had received to the date of his evaluation. He found the treatment provided by Dr. Steiger to be reasonable and appropriate, as was the treatment provided by U.S. HealthWorks Medical Group. While stating that he could not comment on further treatment with Dr. Higashi and Dr. Williams, Dr. Fait did state, "If the examinee actually had 13 epidural steroid injections, in my opinion, this would be quite excessive and exceeds most reasonable recommendations, not to exceed more than two or three epidural injections on an annual basis." Dr. Fait did comment that right total hip replacement, "would seem reasonable and appropriate." I found the opinions and conclusions of Dr. Fait to be substantial medical evidence and persuasive.
…

Lien of California Urgent Care Centers

In regard to the lien of California Urgent Care Centers, they have supplied billings on 7 HICF Forms 1500 for anesthesiology services at COSC on 9/26/11, 12/5/2011, 2/13/12, 4/9/12, 6/18/12, 7/16/12, and 8/2/12 to 10/8/12. They have provided anesthesia reports for dates of service of: 9/26/11, 11/7/11 (no billing form), 12/5/11, 2/13/12, 3/12/12 (no billing form), 4/9/2012, 5/21/12 (no billing form), 6/18/12, 7/16/12, and 10/8/12. There is no anesthesia report to support a billing of 8/2/12. I have no specific information in the exhibits provided by California Urgent Care Centers as to what part of body was being treated at the time the anesthesia was being administered, the scribbled handwritten notes on the anesthesia reports would tend to infer that the procedures on 9/26/2011, 11/7/11, 12/5/11, 2/13/12, 5/21/12, 7/16/12, and 10/8/12 were for the lumbar spine; and the procedures on 3/12/12, 4/9/12, and 6/18/12 were for the thoracic spine. Insofar as the thoracic spine is determined to be non-industrial, defendant is not responsible for those procedures. In regard to the lumbar epidurals and facet injections, it would not be reasonable to do more than two or three per year, according to Dr. Fait, the Panel QME. This opinion is, per my understanding of the MTUS, reasonable. By my calculations, defendant would be reasonably responsible for, at most, three of the lumbar procedures performed, and for none of the thoracic procedures performed.

Insofar as the parties did not break down the Official Medical Fee Schedule allowance for each anesthesia event, I will order the parties to further develop the record in that regard. The parties can attempt to adjust and agree to payment in a reasonable amount for three anesthesia events for the lumbar spine, or they can further litigate the issue when they have further developed the record.

Lien of Comprehensive Outpatient Surgery Center

COSC is relying on the reporting of Grant P. Williams, M.D., whose reporting cannot be construed as carrying much, if any, probative weight. Dr. Williams did not review applicant's pre-injury medical records and he does not have a full and complete medical history, so his reports cannot be construed as substantial medical evidence. Additionally, as noted above, Dr. Fait very clearly indicated that no more than two or three lumbar epidural injections would be reasonable in a one year's span of time and further that applicant did not sustain thoracic spine injury.

In considering the determination that applicant did not sustain injury to the thoracic spine, once again, I am left to wonder how the charges for the services of COSC are to be divided out as between treatment to the lumbar spine, limited to three epidural/facet injections, and treatment to the thoracic spine, and what is the Official Medical Fee Schedule allowance for each of the procedures performed. The parties only provided an overall total, considering lumbar and thoracic separately, but without providing a figure of a per-procedure cost. Thus I require further development of the record, as the parties did not provide the court with sufficient information to make a final determination. The parties can adjust and agree as to what the OMFS would be for three lumbar epidural/facet injections and resolve the lien accordingly, or can litigate the issue further once the record is further developed. …

Other Issues Raised

Insofar as I have determined an issue that was previously undecided, that applicant did NOT sustain injury arising out of and in the course of employment to the thoracic spine, and have ordered further development of the record as to division of the charges for medical treatment for services related to the parts of body stipulated to be compensable (lumbar spine and hips) and charges for medical treatment for services related to parts of body determined to be non-industrial (thoracic spine), I find there are a number of ancillary issues raised at lien trial that likewise must be deferred pending the further development of the record.

…

> I do not have sufficient information to determine if defendant timely objected to all the services remaining in dispute and whether utilization review was timely (or even if UR was accomplished). Until such time as a determination can be made as to what treatment was provided specifically for which parts of body and by what providers, it is difficult, if not impossible, to determine reasonableness and necessity for the treatment provided. Thus, I also cannot determine at this time whether increase and interest applies.

(Report, at pp. 2-6.)

III.

We are not able to provide meaningful review here because the record of proceedings in this case is unclear as to the industrially injured body parts. This matter was first tried on March 12, 2009. At that time, the applicant and defendant stipulated that applicant, "while allegedly employed on January 23, 2008 or January 24, 2008, as an Assistant Manager … claims to have sustained injury arising out of and in the course of employment to his spine, his right lower extremity (hip), head, and hernia." (Minutes of Hearing and Summary of Evidence (MOH/SOE), 3/12/09, at 11:40 am, at p. 2:14-15.) As relevant here, the issue framed for trial was injury arising out of and occurring in the course of employment (AOE/COE). The parties bifurcated all issues except for AOE/COE but did not explicitly defer the issue causation of any specific body part or parts. (MOH/SOE, 3/12/09, at 11:40 am, at p. 2:34-35).

On September 8, 2009, the WCJ issued Findings of Fact. Therein, the WCJ found that applicant "while employed[2] in the late night and early morning hours of January 23, 2008 and January 24, 2008, … sustained his burden of proof that he sustained an injury arising out of and in the course of employment due to a slip and fall." In addition, the WCJ made a finding that "[t]he stipulations in the Minutes of Hearing of March 12, 2009 … are true and are incorporated herein by reference."[3] As noted above, the March 12, 2009 stipulations included applicant's claim of injury to "his spine." (MOH/SOE, 3/12/09, at 11:40 am, at p. 2:14-15.) Moreover, because a finding of injury AOE/COE must include a finding of at least one body part, (Lab. Code, § 3600, 3208; *South Coast Framing, Inc. v. Workers' Comp. Appeals Bd. (Clark)* (2015) 61 Cal.4th 291 [80 Cal.Comp.Cases 489],) the finding of injury AOE/COE coupled with a finding of

[2] While the issue of employment would appear to be among those bifurcated, the WCJ's finding of employment was not challenged on reconsideration.

[3] The WCJ's finding also incorporates by reference stipulations in Minutes of Hearing dated April 22, 2009 and May 27, 2009 but we were unable to find Minutes of Hearing for those dates in EAMS.

incorporation of stipulations by reference may be interpreted as a finding of injury AOE/COE to the "spine" as a whole. This lack of clarity and imprecision of language results in a confusing record and illustrates the reason that the incorporation of stipulations by reference into Findings of Fact are strongly discouraged.

Turning to the merits, we note that in this case, the WCJ relied on the reporting of Dr. Fait, the orthopedic PQME (defendant's Exhibit FF), to find CUCC and COSC each entitled to reimbursement "for no more than three lumbar spine procedures."[4] We find this analysis incomplete.

An employer must provide an injured worker with medical treatment to cure or relieve the injured worker from the effects of an industrial injury. (Lab. Code, §4600.) Timely provision of reasonable medical treatment is an essential element of workers' compensation. (Cal. Const., Article XIV, § 4; *McCoy v. Industrial Acc. Com*. (1966) 64 Cal.2d 82, 87 [31 Cal.Comp.Cases 93]; *Zeeb v. Workmen's Comp. Appeals Bd*. (1967) 67 Cal.2d 496, 501 [32 Cal. Comp. Cases 441]; *Braewood Convalescent Hosp. v. Workers' Comp. Appeals Bd. (Bolton)* (1983) 34 Cal.3d 159, 165 [48 Cal.Comp.Cases 566]; see also, Lab. Code, §4600.) If the employer neglects or refuses to provide reasonable medical care, "the employer is liable for reasonable expense incurred by or on behalf of the employee in providing treatment." (Lab. Code, §4600(a).) The appropriate way for a defendant to dispute whether treatment is reasonable and necessary is through utilization review (UR), and here, defendant submitted no evidence that it had considered the RFAs from lien claimants and proceeded with the UR process as to any of the treatment in dispute. (See Lab. Code, § 4610.)

In addition, it is unclear that Dr. Fait's opinion on the treatment by Drs. Higashi and Williams is substantial medical evidence. Dr. Fait stated:

> I cannot comment on further treatment with Dr. Higashi and Williams. If the examinee had 13 epidural steroid injections, in my opinion, this would be quite excessive and exceeds most reasonable recommendations, not to exceed more than two or three epidural injections on an annual basis. ***However, I cannot comment further as I have no actual documentation of this***.
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> (Defendant's Exhibit FF, emphasis added.)

[4] Findings of entitlement to reimbursement "for ***no more than three*** lumbar spine procedures" (Findings #s 2 & 3, emphasis added) and the subsequent finding that lien claimant Mumtaz Ali, M.D., "***may be entitled*** to reimbursement s once further development of the record has been accomplished" (Finding #4 emphasis added), are likewise imprecise and result in a confusing record.

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 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 mind might accept as adequate to support a conclusion…It must be reasonable in nature, credible, and of solid value." (*Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd (Bolton)* (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566], emphasis removed and citations omitted.)

Decisions of the Appeals Board "must be based on admitted evidence in the record." (*Hamilton v. Lockheed Corporation* (*Hamilton*) (2001) 66 Cal.Comp.Cases 473, 476 (Appeals Board en banc).) An adequate and complete record is necessary to understand the basis for the WCJ's decision. (Lab. Code, § 5313; see also Cal. Code Regs., tit. 8, § 10787.) "It is the responsibility of the parties and the WCJ to ensure that the record is complete when a case is submitted for decision on the record. At a minimum, the record must contain, in properly organized form, the issues submitted for decision, the admissions and stipulations of the parties, and admitted evidence." (*Hamilton, supra,* 66 Cal.Comp.Cases at p. 475.) The WCJ's decision must "set[] forth clearly and concisely the reasons for the decision made on each issue, and the evidence relied on," so that "the parties, and the Board if reconsideration is sought, [can] ascertain the basis for the decision[.] . . . For the opinion on decision to be meaningful, the WCJ must refer with specificity to an adequate and completely developed record." (*Id*. at p. 476 (citing *Evans v. Workmen's Comp. Appeals Bd.* (1968) 68 Cal. 2d 753, 755 [33 Cal.Comp.Cases 350]).)

The WCJ and the Appeals Board have a duty to further develop the record where there is insufficient evidence on an issue. (*McClune v. Workers' Comp. Appeals Bd.* (1998) 62 Cal.App.4th 1117, 1121-1122 [63 Cal.Comp.Cases 261].) The Appeals Board has a constitutional mandate to "ensure substantial justice in all cases." (*Kuykendall v. Workers' Comp. Appeals Bd.* (2000) 79 Cal.App.4th 396, 403 [65 Cal.Comp.Cases 264].) The Board may not leave matters undeveloped where it is clear that additional discovery is needed. (*Id.* at p. 404.)

Finally, we note that while the WCJ addresses the admissibility of Exhibits 304 through 307 in the Opinion on Decision, there has been no actual order admitting them into the record.

Accordingly, we grant reconsideration, rescind the WCJ's decision, and return this matter to the WCJ for further proceedings and decision consistent with this opinion.

For the foregoing reasons,

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

IT IS FURTHER ORDERED, as the Decision After Reconsideration of the Workers' Compensation Appeals Board, that the September 26, 2024 Findings and Order is **RESCINDED,** and that this matter is **RETURNED** to the trial level for further proceedings and decision by the WCJ consistent with this opinion.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

I CONCUR,

/s/ JOSEPH V. CAPURRO, COMMISSIONER

/s/ CRAIG SNELLINGS, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

January 6, 2025

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

COMPREHENSIVE OUTPATIENT SURGERY CENTER
CALIFORNIA URGENT CARE CENTERS
LAW OFFICES OF NICOLE DURANT
ZA MANAGEMENT
SEDGWICK (2)
MUMTAZ ALI, M.D.

PAG/abs

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