WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

MARIA BONILLA, *Applicant*

vs.

EMBER CARE; TECHNOLOGY INSURANCE COMPANY; administered by AMTRUST; LIFE HOUSE HOLDINGS LLC; UNITED STATES FIRE INSURANCE COMPANY, *Defendants*

Adjudication Numbers: ADJ8166020, ADJ8371382, ADJ8371384
Los Angeles District Office

OPINION AND ORDER GRANTING PETITION FOR RECONSIDERATION AND DECISION AFTER RECONSIDERATION

Lien claimants Comprehensive Outpatient Surgery Center, California Urgent Care Center, Technical Surgery Support, Precision Interpreting, ABCDE Transportation, and Reliable Medical Supply (lien claimants) seek reconsideration of the Joint Findings and Orders (F&O), issued by the workers' compensation administrative law judge (WCJ) on August 18, 2025. The WCJ found in pertinent part that the lien claimants did not meet their burden of proof that the services provided were reasonably required to cure or relieve applicant from the effects of an industrial injury and disallowed all their liens.

Lien claimants contend that they met their burden of proof and provided reasonable treatment for all dates of service pursuant to Labor Code[1] section 4600; that the medical treatment services provided were reasonably required to cure or relieve applicant from the effects of an industrial injury; complied with section 4610 and followed conservative treatment guidelines which the parties' agreed medical evaluator (AME) found to be reasonable.

We received an Answer to the Petition for Reconsideration (Answer) from defendant. The WCJ issued a Report and Recommendation on Petition for Reconsideration (Report) recommending that the Petition be denied.

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

We have considered the allegations in the Petition, the Answer, and the contents of the Report with respect thereto. Based on our review of the record, and for the reasons discussed below, we will grant lien claimant's Petition for Reconsideration, rescind the WCJ's Joint F&O, and return this matter to the WCJ for further proceedings consistent with this opinion. This is not a final decision on the merits of any issues raised in the petition and any aggrieved person may timely seek reconsideration of the WCJ's new decision

BACKGROUND

In ADJ8166020, applicant claimed that while employed by defendant as a certified nursing assistant on May 2, 2008, she sustained injury to her arms, fingers, back, and shoulders arising out of and occurring in the course of employment (AOE/COE) when she was attacked by a patient.

In ADJ8371382, while employed as a certified nursing assistant by defendant on November 24, 2011, applicant sustained injury AOE/COE to her right hand and right wrist and claims to have sustained injury to her low back.

In ADJ8371384, while employed as a certified nursing assistant by defendant during the period from April 26, 2011 to April 26, 2012, applicant sustained injury AOE/COE to her right hand, right wrist, left hand, left wrist, and low back.

On March 6, 2013, agreed medical evaluator (AME) Larry A. Danzig, M.D., examined applicant for her claimed injuries, and on March 12, 2013, he issued a report. (Exhibit 19, 3/12/2013.) Dr. Danzig diagnosed applicant with "Low back pain of the sprain/strain variety; Right wrist tendinitis, rule out carpal tunnel syndrome; Left wrist tendinitis, rule out carpal tunnel syndrome." (*Id.*, p. 34.) With respect to causation, he stated that:

> The patient reported and the available medical records indicated that the patient sustained injury to her low back on May 2, 2008 during the course of her employment with Lighthouse Convalescent Hospital/Lighthouse Holdings.
>
> The patient reported and the available medical records indicated that the patient sustained injury to her right hand/wrist on November 24, 2011 during the course of her employment with Lighthouse Convalescent Hospital/Lighthouse Holdings.
>
> Based on the patient's description of the physical demands of her usual and customary work and the patient's physical examination today, it was medically probable that the patient sustained a cumulative trauma injury to her right and left hands/wrists and low back during the course of her employment with Lighthouse Convalescent Hospital/Lighthouse Holdings.

(*Ibid.*)

On August 6, 2013, Dr. Danzig issued a supplemental report. (Exhibit 20, 8/6/2013.) He reviewed a copy of applicant's July 17, 2013 MRI to her lumbar spine. He stated that:

> "the MRI scan shows evidence of a 5 mm extruded disc herniation at L4-LS with significant compromise of· the left LS nerve root." He opined that applicant might need further treatment for her low back complaints, and if she "remained symptomatic, consideration would be given to surgery."

(*Id.* at p. 3.)

On June 9, 2014, Dr. Danzig reexamined applicant and issued a report on June 11, 2014. (Exhibit A, 6/11/14.) He concluded that:

> The patient reported and the available medical records indicated that the patient sustained injury to her low back on May 2, 2008 during the course of her employment with Lighthouse Convalescent Hospital/Lighthouse Holdings.
>
> The patient reported and the available medical records indicated that the patient sustained injury to her right hand/wrist on November 24, 2011 during the course of her employment with Lighthouse Convalescent Hospital/Lighthouse Holdings.
>
> Based on the patient's description of the physical demands of her usual and customary work and the patient's physical examination today, it was medically probable that the patient sustained a cumulative trauma injury to her right and left hands/wrists and low back during the course other employment with Lighthouse Convalescent Hospital/Lighthouse Holdings.

(*Id.* at p. 20.)

He opined that applicant "should have access to an orthopaedic surgeon" and that she might require physical therapy and medication. (*Id.*, p. 27.) As to apportionment, he stated that:

> based on my review of the available medical records and the history given to me by the patient, it is medically probable that approximately ninety percent of the patient's disability for the lumbar spine was caused as a direct result of the patient's cumulative trauma injury which the patient sustained during the course of her employment with Lighthouse Holdings and approximately ten percent to the specific injury of May 2, 2008.
>
> it was medically probable that approximately ninety percent of the disability listed above for the patient's right hand/wrist was caused as a direct result of the patient's cumulative trauma injury which the patient sustained during the course of her employment with Lighthouse Holdings and approximately ten percent to the specific injury of November 24, 2011.

> Based on my review of the available medical records and my physical examination of the patient, it was medically probable that one hundred percent of the disability listed above for the patient's left hand/wrist was caused as a direct result of the patient's cumulative trauma injury which the patient sustained during the course of her employment with Lighthouse Holdings.

(*Id.* at pp. 28-29.)

On May 7, 2015, the parties entered into settlement by way of a Compromise & Release (C&R) in ADJ8166020. Under "total unpaid medical expense to be paid by," it states that: "Defendant only as related to 2008 injury & subject to all defenses in the Labor Code." (C&R, ¶ 6.) Defendant asserted the defense of statute of limitations.

The parties also entered into a C&R in ADJ8371382 and ADJ8371384. Notably, the C&R indicates that defendant paid temporary disability indemnity from March 6, 2013 to May 14, 2013 and permanent disability indemnity from June 11, 2014 to December 23, 2014. (C&R, ¶ 6.) It further states that: "PER AME DANZIG THE CLAIMS RATE TO 13%WPI, WHICH IS $9,717.50 IN PD. THE REMAINING BALANCE WILL BE RESERVED FOR FUTURE MEDICAL CARE." (C&R, ¶ 9.) That same day, the WCJ issued orders approving each of the two C&Rs.

On July 26, 2024, lien claimants and defendant proceeded to trial. In ADJ8166020, defendant raised the issue of injury arising out of and in the course of employment. In ADJ8371382, defendant stipulated to injury to applicant's right hand and right wrist, but raised the issue of injury to the low back. In ADJ8371384, defendant stipulated to injury to applicant's right hand, right wrist, left hand, left wrist, and low back. The issue of the liens was raised in all cases.

On September 10, 2024, the WCJ issued a Joint Findings & Orders. As relevant herein, the WCJ found that applicant did not sustain injury AOE/COE to her arms, fingers, back, or shoulders on May 2, 2008. In his Joint Opinion on Decision, the WCJ stated that he disregarded the opinion of Dr. Danzig because his opinion was "not stated in terms of reasonable medical probability." (Opinion, p. 1.)

On September 25, 2024, lien claimants filed a timely Petition for Reconsideration.

On December 9, 2024 we issued our Opinion and Order Granting Petition for Reconsideration and Decision After, wherein we rescinded the Findings of Fact and substituted a new Findings of Fact that applicant sustained injury AOE/COE in ADJ8166020 on May 2, 2008. We returned this matter to the WCJ for further proceedings and a new decision consistent with our opinion.

On May 30, 2025, the matter came on for lien trial. The minutes state, "that the matter returns back on calendar following the Opinion and Order from WCAB dated December 9, 2024, remanding the matter back so the Court is going to resubmit the matter on the issues that were started back on July 26, 2024." (Minutes of Hearing, 5/30/2025, p. 2.) The issues listed on July 26, 2024, Minutes of Hearing are as follows for ADJ8166020 Master File: 1. Injury AOE/COE. 2. Liens: a) Comprehensive Outpatient Surgery Center, seeking reimbursement for medical treatment expense. b) Technical Surgery Support, seeking reimbursement for medical treatment expense. c) California Urgent Care seeking treatment for medical expense. d) Precision Interpreting, seeking reimbursement for interpreting expense. e) Reliable Medical Supply, seeking reimbursement for medical treatment expense. f) ABCDE Transportation, seeking reimbursement for medical treatment expense. 3. Lien statute of limitations, whether the applicant's case was filed within the statute of limitations. 4. Presumption of compensability., 5. Penalty and interest. 6. Necessity of the services and/or underlying services. . 7. Value of the charges. (Minutes of Hearing, 7/26/2024, p. 3.) The issues listed for ADJ8371384 and ADJ8371382 are the same for the liens as in ADJ8166020.

On August 18, 2025, the WCJ issued a Joint Findings & Orders and Opinion on Decision. As relevant herein, the WCJ found that none of the lien claimants met their burden of proof to recover on their liens.

On September 3, 2025, lien claimants filed a Petition for Reconsideration.

DISCUSSION

I.

Former 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.

(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 September 15, 2025, and 60 days from the date of transmission is November 14, 2025. This decision is issued by or on November 14, 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 September 15, 2025, and the case was transmitted to the Appeals Board on September 15, 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 September 15, 2025.

II.

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].) 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." (*Braewood v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566] (italics and quotation marks omitted).)

When a lien claimant is litigating the issue of entitlement to payment for industrially related medical treatment, the lien claimant stands in the shoes of the injured employee and must prove by a preponderance of the evidence all of the elements necessary to the establishment of its lien. (*Kunz v. Patterson Floor Company, Inc.* (2002) 67 Cal.Comp.Cases 1588 (Appeals Bd. en banc); *Tapia v. Skill Master Staffing* (2008) 73 Cal.Comp.Cases 1338 (Appeals Bd. en banc); *Torres v. AJC Sandblasting* (2012) 77 Cal.Comp.Cases 1113 (Appeals Bd. en banc).) Lien claimants bear the burden of proof to establish that the medical treatment services they provided were reasonable and necessary to cure applicant from the effects of their industrial injury. (*State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (*Sandhagen*) (2008) 44 Cal.4th 230, 237-238 [73 Cal.Comp.Cases 981]; *Tito Torres v. AJC Sandblasting* (2012) 77 Cal.Comp.Cases 1113, 1121 [2012 Cal. Wrk. Comp. LEXIS 160] (Appeals Board en Banc).)

Here, Comprehensive Outpatient Surgery Center, Technical Surgery Support, California Urgent Care, Precision Interpreting, ABCDE Transportation, and Reliable Medical Supply are "medical treatment liens." Section 4600(a) requires the employer to provide medical treatment and services to an industrially related injured employee:

> Medical, surgical, chiropractic, acupuncture, licensed clinical social worker, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of the worker's injury shall be provided by the employer. In the case of the employer's neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(Lab. Code, § 4600(a).)

Subsection (b) of section 4600 defines reasonable and necessary medical treatment as: "medical treatment that is reasonably required to cure or relieve the injured worker from the effects

of the worker's injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27."[2]

On July 16, 2012, Marina Russman, M.D., examined applicant and issued an initial report for pain management. In the report, Dr. Russman recommended a lumbar facet joint block at the medial branch at levels L2-L3, L3-L4, IA-L5 and L5-Sl bilaterally. Dr. Russman states,

> This patient should receive clearance from an internal medicine specialist prior to proceeding with this procedure. Additionally, I would like to recommend the patient undergo a psychological evaluation to determine if the patient is sufficiently stable and secure emotionally to undergo this procedure. (Exhibit 21, 7/16/2012, p. 9.)
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> ***
>
> Based on these findings, I am recommending the patient undergo a lumbar facet joint block at the medial branch at levels L2-L3, L3-L4, IA-L5 and L5-Sl bilaterally. If there is successful axial pain relief of greater than 70% for up to four hours, then we plan to proceed with a rhizotomy at the levels that meet this criteria. If there is less than adequate relief, a repeat for confirmation or change of blocked levels may be the next step. The innervation of the lumbar facet joints is critical for understanding which nerve levels will be affected by this procedure. It is this medial branch of the dorsal primary ramus that supplies the sensation for the facet joints. The dorsal primary ramus loops posteriorly and splits into a lateral branch, intermediate branch ai1d a medial branch. The course of the medial branch of the dorsal primary ramus is such that each facet joint has dual innervations. Therefore, the reflected medial branch affected may include the level above or the level below to accommodate the two levels with facet pathology.
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> I will perform the recommended procedures during the same visit for three reasons: l) to decrease the anesthetic exposure to the patient; 2) to decrease the travel time for the patient, who lives more than than 20 miles/60 minutes from the surgery center; 3) to decrease the over-all additional hardship on the patient by decreasing the number of times she must travel and be anesthetized for these procedures.
>
> This patient should receive clearance from an internal medicine specialist prior to proceeding with this procedure. Additionally, I would like to recommend the patient undergo a psychological evaluation to detem1ine if the patient is sufficiently stable and secure emotionally to undergo this procedure. I have reviewed the potential risks, benefits and complications with the patient. It has been explained to the patient that the procedure may be modified based on real-time multi-planar fluoroscopy in the operating room (i.e. caudal vs. transforaminal). The patient has presented a clear understanding and wishes to proceed. ***Therefore, please consider***

[2] We note that in 2008, former section 4600(b)included the following language in the definition of medical treatment: "or prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines." (Former Lab. Code, § 4600(b), Stats. 2006, ch. 819, § 2. Stats. 2012, ch. 363, § 35 [Senate Bill (SB) 863 amended section 4600(b) to its current version.].)

this a written request for authorization and review this request immediately upon receipt. (bold and italics added for emphasis) (Exhibit 21, 7/16/2012, p.11.)

The WCJ in his Joint Opinion on Decision stated,

NECESSITY OF SERVICES/COMPREHENSIVE OUTPATIENT SURGERY CENTER (COSC)/TECHNICAL SURGERY SUPPORT/URGENT CARE

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-lega [*sic*] procedures to dispute a request 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 changes to Labor Code section 4600 as a result of the enactment of SB 899 on 4/19/04, apply prospectively to undecided lien issues regardless of the date of injury (*Sierra Pacific Industries v. WCAB* (*Chatham*)(2006) 71 CCC 714).

The medical treatment services provided at COSC consisted of lumbar ACEOM guidelines epidural steroid injections and lumbar facet joint blocks requested and performed by Marina Russman M.D. on 11/15/12 and 1/24/13. Be that as it may, Lien Claimant did not provide any evidence that the medical treatment services provided were in accordance with the MTUS. Providing such evidence is an essential element of Lien Claimant's burden of proof. Thus, Lien Claimant did not meet its burden to prove that the medical treatment services it provided were reasonably required to cure or relieve from the effects of said injury or injuries.

Here, we disagree with the WCJ's Joint Opinion on Decision where he states,

. . . ***Lien Claimant did not provide any evidence that the medical treatment services provided were in accordance with the MTUS***. ***Providing such evidence is an essential element of Lien Claimant's burden of proof***. ***Thus, Lien Claimant did not meet its burden to prove that the medical treatment services it provided were reasonably required to cure or relieve from the effects of said injury or injuries***.

As stated by the WCJ, in the Joint Opinion on Decision, the first procedure was on November 15, 2012, and the second procedure was on January 24, 2013. The WCJ further asserts, "Lien Claimant did not provide any evidence that the medical treatment services provided were in accordance with MTUS." We disagree.

Here, applicant's injuries occurred prior to 2013, and since AME Dr. Danzig was appointed and evaluated applicant on two occasions, it was his role to comment on the reasonableness and necessity of the treatment applicant received. In his March 12, 2013 report Dr. Danzig opines, "The patient also treated with Dr. Marina Rasmussmen [*sic*]. The patient had two lumbar epidural steroid injections which were very helpful." (Exhibit 19, 3/12/2013, p. 7.) Dr. Danzig also issued a report on June 11, 2014, where he further opined,

> The low back pain was improved since last evaluated by me. Currently, the patient's low back pain was present all the time and radiated to both legs to the level of her knees. The patient's low back pain was increased with lifting, bending, prolonged sitting, prolonged walking, prolonged standing, and climbing. The patient had tingling and numbness in both legs to the level of her knees. The patient did not have any weakness in her lower extremities.

(Exhibit A, 6/11/2014, p. 3.)

Next, we will examine the lien claim for the durable medical equipment from Reliable Medical Supply. Dr. Russman's recommendation in her initial pain management consultation reported that applicant use a cold unit or durable medical equipment to treat sequelae arising out of applicant's industrial injuries. (Exhibit 21, 7/16/2012, p. 9.) Dr. Russman prescribed a therapeutic ball and a cane. (Exhibit 24, January 2, 2013, p. 6.) Reliable Medical Supply dispensed a cold/hot unit, inflatable theraband ball, and a cane as shown on an invoice with applicant's name and dated August 17, 2023. (Exhibit 1, 8/17/2023.) Dr. Russman prescribed the cold/ hot unit, ball, and cane for applicant as evidenced by Dr. Russman's July and January reports and Reliable Medical Supply's ledger. (Exhibit 1, 8/17/2023.)

Dr. Russman prescribed durable medical equipment for applicant as evidenced by her reports and the invoice, but the WCJ found that Reliable Medical Supply did not meet its burden to prove that the medical treatment services were reasonably required to cure or relieve applicant from the effects of an industrial injury. Dr. Russman recommended that applicant use the durable medical equipment. (Exhibit 21, 7/16/2012, p. 9.) Dr. Russman as applicant's treating physician

performed her two injection procedures and monitored her treatment and care prescribed the equipment, and she determined what was reasonable and necessary for applicant's medical care.

Applicant is a Spanish speaker and in order to communicate with her doctors at her medical appointments, she needed translation services. She has been provided with translation services at her medical treatment appointments. The WCJ found that lien claimant Precision Interpreting, LLC, did not establish that any of its interpreters utilized at applicant's medical treatment appointments were certified.

In the WCJ's Opinion on Decision, the WCJ states that there were no medical reports in evidence establishing that there was a medical examination of applicant on July 16, 2012, or August 22, 2012. This is not correct. Dr. Russman issued a report on July 16, 2012, after her initial examination and consultation with applicant, and on the last page of her report it states "Translation, where necessary, was provided by an interpreter." (Exhibit 21, 7/16/2012, p. 11.) On August 22, 2012, applicant needed the assistance of a translator for a surgical clearance appointment. There is a completed Interpreter Declaration in evidence which indicates that applicant was assisted at this appointment with Dr. Labrsky by an interpreter. (Exhibit 9, 2/12/2013.)

Section 4600(f)[3] provides for a reasonable fee for "qualified interpreters" at a required medical "examination." These services shall be provided by the employer. Section 4600(g) provides that if the injured employee cannot effectively communicate with their treating physician because the employee cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments.

We previously addressed the issue of interpreter services in connection with medical treatment in *Guitron v. Santa Fe Extruders* (2011) 76 Cal.Comp.Cases 228, 243 (Appeals Board en banc), wherein we held that in order "to recover its charges for interpreter services, the interpreter lien claimant has the burden of proving, among other things, that the services it provided were reasonably required, that the services were actually provided, that the interpreter was qualified to provide the services, and that the fees charged were reasonable." (*Id.* at p. 243.) With respect to the issue of certification, we observed the following:

[3] For purposes of this section, "qualified interpreter" means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code. (Lab. Code, § 4600(f).)

> An interpreter lien claimant must also prove that the interpreter was qualified to provide the billed services. (Lab. Code, § 5705; *Capi*, *supra*, 138 Cal.App.4th 373 [71 Cal. Comp. Cases 374]; *Stokes v. Patton State Hospital* (2007) 72 Cal. Comp. Cases 996 (Significant Panel Decision).) Pursuant to AD Rule 9795.3(a), a "qualified interpreter" may provide services for a medical examination requested by the claims administrator, AD, or appeals board, or at a comprehensive medical-legal evaluation. A "qualified interpreter" means a "certified" or "provisionally certified" interpreter pursuant to AD Rule 9795.1(f) (Cal. Code Regs., tit. 8, § 9795.1(f)), or, for purposes of section 4600, a "qualified interpreter" means an interpreter certified or deemed certified pursuant to the Government Code.
>
> When the setting is not "an appeals board hearing, arbitration, or formal rehabilitation conference," and when a certified interpreter cannot be present, a "provisionally certified" interpreter is one deemed qualified to perform interpreting services by agreement of the parties. (Cal. Code Regs., tit. 8, § 9795.1(e).) Thus, for a medical examination, a provisionally certified interpreter is one deemed qualified by agreement of the parties, when a certified interpreter is unavailable. While a treatment appointment is not strictly governed by these provisions, we see no logical reason why the qualifications for an interpreter at a treatment appointment should be any different or less rigorous than the qualifications for an interpreter at a medical examination. If certified interpreters are difficult to obtain, as stated by E&M, agreement by the parties is unquestionably the best option for obtaining a "provisionally certified" and, therefore, "qualified" interpreter.
>
> Government Code section 11435.55 suggests another option. It provides that, when a certified interpreter cannot be present at a medical examination, "the physician provisionally may use another interpreter if that fact is noted in the record of the medical evaluation." While agreement between the parties is preferred, a non-certified interpreter lien claimant seeking payment for services performed during medical treatment could show that it was selected "provisionally," under Government Code section 11435.55, if use of the non-certified interpreter is recorded by the physician. Thus, in the absence of any directly applicable authority on qualifications for interpreters during medical treatment, an interpreter may be qualified to interpret at medical treatment appointments because he or she is certified for interpreting at medical examinations or deemed certified for medical examinations by virtue of being certified for court or administrative hearing interpreting, or, if a certified interpreter is unavailable, the interpreter is provisionally certified by agreement of the parties or selected for provisional use by the treating physician.

(*Id*. at pp. 246-247.)

Here, the WCJ determined that "Precision Interpreting did not establish that any of its interpreters utilized at applicant's medical treatment appointments were qualified." However, it appears from this record that the WCJ did not apply the analysis described in *Guitron*, including a

determination of whether the interpreters at the medical appointments were provisionally certified. As to the actual amount to be paid for interpreter services, the provisions of AD Rule 9795.3 are relevant to the issues herein. (Cal. Code Regs., tit. 8, § 9795.3.)

Last, we will examine the issue of medical transportation. Section 4600(e)(1) provides that,

> When ***at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, the employee submits to examination by a physician***, the employee is entitled to receive, in addition to all other benefits herein provided, ***all reasonable expenses of transportation***, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination. (bold and italics added for emphasis)

(Lab. Code, § 4600 (e) (1).)

Here, the evidence in the record of proceedings from ABCDE Transportation is a ledger with a date range of August 22, 2021 through January 24, 2013 with the CPT Code, Diagnosis/Descriptions Provider, Units Charges, Paid, Adjustments, and Balance headings which lists drop-off services for applicant to numerous medical appointments with very little detail. (Exhibit 4, 8/17/2013.) The ledger lacks details such as the doctor's name, address etc., and this makes it difficult to discern the validity of the records. Transportation to and from medical appointments is reasonable and necessary, but more information is needed from ABCDE Transportation to determine if they met their burden of proof that the transportation services it provided were in conjunction with medical treatment appointments which were reasonable and necessary to cure or relieve from the effects of applicant's industrial injury. ABCDE Transportation must provide the WCJ with specific details regarding (i.e., the name of the doctor's office and/or medical facility that applicant was transported to and from and when), the transportation services provided in this matter.

III.

The statutory and regulatory duties of a WCJ include the issuance of a decision that complies with section 5313. A WCJ is required to "make and file findings upon all facts involved in the controversy and an award, order, or decision stating the determination as to the rights of the parties. Together with the findings, decision, order or award, there shall be served upon all the parties. The endorsement to the proceedings a summary of the evidence received and relied upon and the reasons or grounds upon which the determination was made." (Lab. Code, §§ 5502, 5313; Cal. Code Regs., tit. 8, § 10761; see also *Blackledge v. Bank of America*, *ACE American Insurance*

Company (2010) 75 Cal.Comp.Cases 613, 621-622 (Appeals Board en banc).) 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).)

As required by section 5313 and explained in *Hamilton*, "the WCJ is charged with the responsibility of referring to the evidence in the opinion on decision, and of clearly designating the evidence that forms the basis of the decision." (Lab. Code, § 5313; *Hamilton*, *supra*, at p. 475.) In *Hamilton*, we held that the record of proceeding must contain, at a minimum, "the issues submitted for decision, the admissions and stipulations of the parties, and the admitted evidence." (*Ibid*.) The WCJ's opinion on decision "enables the parties, and the Board if reconsideration is sought, to ascertain the basis for the decision, and makes the right of seeking reconsideration more meaningful." (*Hamilton*, *supra*, at p. 476, citing *Evans v. Workmen's Comp. Appeals Bd.* (1968) 68 Cal.2d 753, 755 [33 Cal.Comp.Cases 350].)

Here, with extensive medical treatment evidence and other evidence in the record of proceedings, it was inappropriate for the WCJ to interject himself into the medical and other decisions when determining that lien claimants did not meet their burden of proof that the services provided were not reasonably required to cure or relieve applicant from the effects of an industrial injury. The record needs to be further developed consist with the decision herein.

Accordingly, we grant the Petition for Reconsideration, rescind the F&O and return the matter to the trial level for further proceedings consistent with this decision.

For the foregoing reasons,

IT IS ORDERED that lien claimant's Petition for Reconsideration of August 18, 2025 Joint F&O is **GRANTED**.

IT IS FURTHER ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the August 18, 2025 Joint F&O is **RESCINDED**, and that the matter is **RETURNED** to the trial level for further proceedings consistent with this decision.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

I CONCUR,

/s/ JOSÉ H. RAZO, COMMISSIONER

/s/ JOSEPH V. CAPURRO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

November 14, 2025

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

ZA MANAGEMENT
CHERNOW PINE & WILLIAMS

DLM/oo

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