WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

VIVIANA ELIZABETH TABOADA, ***Applicant***

vs.

STATE OF CALIFORNIA DEPARTMENT OF SOCIAL SERVICES/IHSS, legally uninsured, administered by YORK RISK SERVICES GROUP, ***Defendants***

Adjudication Number: ADJ11775583
Van Nuys District Office

OPINION AND DECISION AFTER RECONSIDERATION

We previously granted reconsideration[1] in this matter to provide an opportunity to further study the legal and factual issues raised by the Petition for Reconsideration. Having completed our review, we now issue our Decision After Reconsideration.

Defendant seeks reconsideration of the November 9, 2021 Findings and Orders (F&O), wherein the workers' compensation administrative law judge (WCJ) found that applicant, while employed as a caregiver on November 24, 2018, sustained industrial injury to her right hip and right lower extremity. The WCJ found that applicant was in need of ongoing interim home health care services and that defendant had not met its burden of identifying a permanent home health care services solution. Accordingly, the WCJ ordered defendant to continue to provide the requested interim home health care services until a permanent solution could be identified or until such time as there was a change in applicant's circumstance or condition.

Defendant contends that there is no evidence that the need for the home health care services is due to the industrial injury; that there was insufficient evidence to cause a shift in the burden of proof to defendants; that home health care services which have been approved on a limited basis are not subject to an analysis under applicable case law authority; and that the Workers' Compensation Appeals Board (WCAB) lacks jurisdiction to adjudicate this issue.

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[1] Commissioner Sweeney, who was previously a member of this panel, no longer serves on the Workers' Compensation Appeals Board. Another panelist has been substituted in her place.

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

We have considered the Petition for Reconsideration, the Answer, and the contents of the Report, and we have reviewed the record in this matter. For the reasons discussed below, we will affirm the F&O, except that we will amend Finding of Fact No. 3 to reflect that the Utilization Review decision of February 16, 2021 determined that the nature of applicant's condition requires the provision of continued home health care services until a more specific, permanent solution is found. We will then amend the Order to reflect that defendant must continue to provide the specified home health care services, six hours per day, five days per week, until such time as the parties can demonstrate reasonable efforts to identify and implement a permanent solution to applicant's need for home health care services.

FACTS

Applicant sustained injury to her right hip and right lower extremity while employed as a caregiver by defendant State of California Department of Social Services/IHSS on November 24, 2018. Applicant fell while performing her usual and customary caregiving duties. Defendant admits industrial injury to the right hip and right lower extremity but disputes injury to the shoulders, upper extremities, lumbar spine, psyche, diabetes, hypertension, and eyes.

Applicant has selected Lawrence Miller, M.D., as her primary treating physician (PTP) in pain management. The parties have also selected Richard Nussbaum, M.D., as the Qualified Medical Evaluator (QME) in orthopedic medicine.

On November 23, 2020, PTP Dr. Miller evaluated applicant, who related the following history:

> [Applicant] was in the bedroom of the backhouse undressing her client in order to bathe her when her client unintentionally pushed Ms. Taboada backwards. Ms. Taboada fell to the ground. She struck her right hip/ thigh area against a small step that divided the bedroom from the living room. The pain in the right pelvic/thigh area was excruciating. She nearly passed out. She was transported via ambulance to Verdugo Hills Hospital. She was diagnosed with a right intertrochanteric hip fracture. She underwent ORIF of the hip fracture. She was hospitalized for three days and then transferred to a nursing center, where she would spend the next year and 11months in rehabilitation. She was bedridden through most of the hospitalization. Her diabetes was poorly managed, and her

> vision was severely impacted. She is now almost completely blind. During the nursing home stay, she also had recurrent leg cellulitis. Following her discharge from the hospital, her son takes care of her. He provides her with her insulin and blood sugar monitoring as she is nearly completely blind. She has developed urinary incontinence and is in diapers. Her care has now been transferred to the undersigned with authorization only for treatment of her right leg. Clearly, there have been other complications from the injury including postphlebitic syndrome with recurrent cellulitis, loss of sight, urinary incontinence, aggravation of diabetes and deconditioning.

(Ex. 5, Report of Lawrence Miller, M.D., dated November 23, 2020, p. 1.)

Dr. Miller observed that applicant "requires assistance for all activities of daily living," and that applicant's son "assists her with bathing, preparing meals, using the toilet, and getting dressed. She has very poor vision and does not venture out on her own. She is afraid of falling and injuring herself. She is also suffering from urinary incontinence." (*Id.* at p. 5.) Dr. Miller's summary noted applicant to be "an unfortunate 62-year-old former caregiver who is doing poorly following a work fall resulting in intertrochanteric fracture." (*Id.* at p. 11.) Applicant was observed to be "barely functioning," with "marked induration of both lower extremities with erythema and postphlebitic changes." (*Ibid*.) Dr. Miller instituted a multi-modality treatment plan including durable medical equipment and a home health care consultation.

On December 3, 2020, a utilization review (UR) physician certified various requested treatment modalities as medically necessary, including the purchase of adult diapers, a wheelchair, a shower chair, a toilet lift, and a course of aquatic therapy. (Ex. 3, UR Determination, dated December 3, 2020.) In a separate UR decision on the same day, a UR physician certified the requested nursing home care assessment and consultation. (Ex. 4, Utilization Modified Approval, dated December 3, 2020.)

On December 17, 2020, QME Dr. Nussbaum conducted an orthopedic evaluation of applicant, and diagnosed intratrochanteric and subtrochanteric right femur fracture, status post open reduction and internal fixation, and a sprain/strain right shoulder and right wrist. Dr. Nussbaum further identified collateral nonindustrial diagnoses including chronic bilateral knee pain secondary to osteoarthritis and morbid obesity, morbid obesity, poorly controlled diabetes mellitus, insulin dependent diabetes mellitus, and triggering bilateral middle fingers. (Ex. B, Report of Richard Nussbaum, M.D., dated December 17, 2020, at p. 28.) The QME identified permanent partial disability and indicated that applicant would need continuing medical care. (*Id.* at p. 29.)

On January 4, 2021, PTP Dr. Miller reevaluated applicant, noting that "the patient continues to do poorly. She is pending home care assessment to outline homecare needs." (Ex. 6, Report of Lawrence Miller, M.D., dated January 4, 2021.)

On February 16, 2021, UR physician Dr. Taff reviewed a Request for Authorization (RFA) submitted by PTP Dr. Miller, requesting home health care services of 6 hours per day, 7 days per week, for 12 weeks; a stationary bike rental for 90 days; and adult diapers. (Ex. 1, UR Determination, dated February 16, 2021, at p. 1.) The physician reviewer certified applicant's home health care services request as medically necessary but modified the request to reduce the allotment to "90 hours, 6 hours a day 5 days a week." (*Ibid*.) The physician explained that "there should be some other source of permanent health care given that [applicant's] condition is more of a prominent (sic) condition rather than temporary … it is necessary to provide some assistance in the interim until a more specific, permanent solution is found for her condition." (*Id.* at p. 4.)

Applicant thereafter appealed the UR decision modifying the requested home health care treatment to Independent Medical Review (IMR).

On March 16, 2021, PTP Dr. Miller submitted an RFA again requesting, in relevant part, home health care services of six hours per day, seven days per week, for 12 weeks, based on the recommendations of the home health care evaluation performed by a nurse on January 6, 2021. (Ex. 8, Report of Lawrence Miller, M.D., dated March 16, 2021, at p. 1)

On March 25, 2021, a UR physician partially non-certified the March 16, 2021 request insofar as it requested additional hours of home health care services but also noted that the modified authorization for home health care services of six hours per day, five days per week, was not reviewed as it had been authorized. (Ex. C, UR Determination, dated March 25, 2021, p. 3.) The reviewing physician addressed the requested increase in weekly hours of home health care services by noting that "[t]here is no indication that the patient is currently homebound," and because "home healthcare services are recommended for short-term use only with no exceptional factors in which to continue ongoing care … the request is not medically necessary and is noncertified." (*Id.* at p. 5.)

On April 12, 2021, an IMR physician upheld the February 16, 2021 UR decision, finding that the requested levels of home health care services at six hours per day, *seven days per week*, was not medically necessary. (Ex. E, IMR Determination, dated April 12, 2021, at p. 4.) However, insofar as the March 25, 2021 UR decision certified home health care services of 6 hours per day,

five days per week, the UR physician's decision to modify the RFA was left undisturbed as the treatment was authorized.

On May 18, 2021, an IMR physician upheld the March 25, 2021 UR non-certification of the requested increase in hours for home health care services. (Ex. F, IMR Determination, dated May 18, 2021, at p. 1.) The decision noted "[t]he information on file failed to support or substantiate the request." (*Id.* at p. 4.)

On October 27, 2021, the parties proceeded to trial and framed for decision the issue of applicant's entitlement to medical treatment; whether the court had the necessary jurisdiction to hear and decide the dispute; and whether defendant was required to continue to authorize the home health care services that it had authorized pursuant to the February 16, 2021 UR determination. (Minutes of Hearing and Summary of Evidence (Minutes), dated October 27, 2021, at p. 2:19.) The WCJ heard testimony from applicant and ordered the matter submitted for decision.

On November 9, 2021, the WCJ issued the F&O, determining in relevant part that "[t]he utilization review modification found some assistance is needed in the interim until a more specific, permanent solution will be found. This is enough to switch the burden to Defendant to show a permanent solution has been found, negating the necessity of interim care." (F&O, Finding of Fact No. 3.) The WCJ ordered defendant to continue to provide home health care services at existing levels of six hours per day, five days for week, "until there is a permanent solution found or other change in circumstances." (F&O, "Orders.")

Defendant's Petition contends the medical record does not distinguish between applicant's industrial and nonindustrial conditions, and consequently there is no evidence that the need for the home health care services is due to the industrial injury. (Petition, at p. 4:24.) Defendant asserts that notwithstanding the conclusion of the UR physician that continued home health care services would be required until a more specific permanent solution is found, "there is nothing implicit in this decision which places the burden of finding that solution on defendants." (*Id.* at p. 5:1.) Defendant observes that applicant bears the initial burden of establishing the medical necessity of the requested treatment. Defendant also observes that Dr. Miller requested a closed period of home health care services, and that additional requests thereafter must be filed and evaluated on an individual basis. Finally, defendant asserts the WCAB lacks the requisite jurisdiction to hear or decide issues of medical necessity that are otherwise governed under the UR/IMR process. (*Id.* at p. 7:21.)

Applicant's Answer responds that the only evidence cited to support defendant's conclusion that there is no evidence of the need for home health care services is the very same February 16, 2021 UR decision that *authorized* home health care services. Applicant also observes that defendant authorized the modified levels of home health care services identified in the February 16, 2021 UR decision, and that pursuant to the UR physician's stated rationale for certification, defendant was obligated to provide such treatment until a "permanent solution" for applicant's need for home health care services was identified and implemented. (*Id.* at p. 5:15.)

The WCJ's Report observes that provision of medical treatment is not subject to apportionment, and that the evidentiary record supports industrial contribution to applicant's need for home health care services. (Report, at p. 3.)

DISCUSSION

I.

We begin our discussion with defendant's contention that we lack the jurisdiction to address the instant dispute. (Petition, at p. 7:21.)

The jurisdiction of the Appeals Board over medical treatment disputes arising under California's workers' compensation system is provided by Labor Code[2] sections 4604 and 5304. Section 5304 states in pertinent part that "[t]he appeals board has jurisdiction over any controversy relating to or arising out of Sections 4600 to 4605…." (Lab. Code, § 5304; see §§ 5300, 5301.) Section 4604 provides that "[c]ontroversies between employer and employee arising under this chapter shall be determined by the appeals board, upon the request of either party, except as otherwise provided by Section 4610.5." (Lab. Code, § 4604.)

Pursuant to section 4610.5, IMR is the exclusive remedy for an employee challenging a valid, timely UR determination. (Lab. Code, § 4610.5(a).) Section 4610.5 provides for review of disputes by IMR when UR has modified or denied the medical treatment request as not medically necessary. UR decisions validly obtained in compliance with section 4610 will trigger the IMR process of section 4610.5, in which case jurisdiction over the controversy rests solely with the IMR process.

In contrast, when the underlying UR decision is not validly obtained or is not timely pursuant to section 4610, there is no basis upon which to trigger the IMR process of section 4610.5.

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

By its own terms, an employee may only invoke IMR when "a utilization review decision denies or modifies a treatment recommendation based on medical necessity." (Lab. Code, § 4610 (d).) If there is no valid UR decision, there is no basis upon which to invoke IMR. In the absence of a controversy subject to section 4610.5, jurisdiction over medical treatment issues rests with the Appeals Board. (Lab. Code, § 4604.)

Defendant contends that insofar as the current dispute arises out of a UR decision that modified or denied a request for medical treatment in the form of home health care, section 4604 reserves sole jurisdiction over the dispute to the IMR process described in section 4610.5. (Petition at p. 7:21.)

In order to trigger the UR and IMR processes of sections 4610, 4610.5 and 4610.6, the underlying RFA must present an unresolved question of medical necessity. The Appeals Board is authorized to make an initial factual inquiry into whether the factual circumstances underlying an RFA and the resulting medical dispute gave rise to a valid, timely UR determination. When a valid RFA results in a timely UR decision the Appeals Board has no jurisdiction over the dispute, and IMR is the sole avenue by which an employee may challenge the UR decision. However, the IMR process is only available when a valid, timely UR decision modifies or denies an otherwise valid treatment request. (Lab. Code, §§ 4610.5; 4610.6.) Both statutory and case law authority illustrate multiple instances in which an RFA or a UR decision will not ultimately trigger IMR.

For example, an RFA would not trigger UR when the employer is denying all liability for the claim (Lab. Code, § 4610(l)), or when the RFA is for treatment that was previously denied within the last 12 months, absent a showing of change in the facts material to the prior UR decision (Lab. Code, § 4610(k).) Similarly, an RFA would not trigger a valid UR process when the parties agree to entirely displace the UR process for a particular treatment. (*Allied Signal Aerospace v. Workers' Comp. Appeals Bd.* (*Wiggs*) (2019) 35 Cal.App.5th 1077 [84 Cal.Comp.Cases 367] (*Wiggs*).) In the absence of a properly raised dispute subject to UR, the UR process is inapplicable. IMR is similarly unavailable in the absence of a valid, underlying UR decision from which an employee may appeal. Thus, a UR decision that issues beyond the strict timelines imposed by the Legislature under section 4610 is invalid and does not trigger IMR. (*Wiggs*, *supra*, 35 Cal.App.5th at p. 1081; *Dubon v. One World Restoration* (2014) 79 Cal.Comp.Cases 1298 (Appeals Bd. en banc).) In all of these examples, the limited but exclusive jurisdiction of IMR arises only when a valid RFA results in a timely UR decision modifying or denying a requested medical treatment for

reasons of medical necessity. The IMR process is inapplicable absent these statutory prerequisites. Because IMR is inapplicable in each of these examples, any underlying disputes must be resolved before the Appeals Board. (Lab. Code, § 4604.)

In addition, the Legislature specifically contemplated that the Appeals Board retain jurisdiction to hear and decide medical treatment disputes not otherwise subject to the IMR process. Indeed, as part of the reform legislation of SB863, section 4604 was amended to provide for the jurisdiction of IMR over controversies arising under section 4610.5 while at the same time *reaffirming* that upon the request of either party, "[c]ontroversies between employer and employee arising under this chapter shall be determined by the appeals board." (Lab. Code, § 4604.) This jurisdiction aligns with section 5304, a statute that has remained virtually unchanged for more than 100 years, which provides the Appeals Board with express jurisdiction over "any controversy relating to or arising out of Sections 4600 to 4605 inclusive," absent an express agreement between the parties fixing reimbursement value. (Lab. Code, § 5304.) Pursuant to this grant of jurisdiction, the Appeals Board hears issues ranging from whether there has been a change in the facts material to a prior UR decision modifying or denying an RFA under section 4610(k), to challenges to the timeliness of a UR determination under section 4610, and even challenges to whether the parties have stipulated to displace the UR process altogether. (*Wiggs*, *supra*, 35 Cal.App.5th 1077; *Dubon*, *supra*, 79 Cal.Comp.Cases 1298.) In these instances, the Appeals Board does not decide questions of medical necessity because that is the exclusive province of UR/IMR. However, insofar as the challenge is to collateral issues attendant to the UR/IMR process, issues such as the sufficiency of the triggering RFA, or the timeliness of the UR decision, these are decisions within the express jurisdiction of the Appeals Board.

The Legislature's decision to vest the Appeals Board with jurisdiction to hear and decide issues ancillary to the IMR process is further evidenced in the post-IMR appeal process. Pursuant to section 4610.6(h), IMR determinations "may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer." (Lab. Code, § 4610.6(h).) As the First Division of the California Court of Appeal has observed:

> IMR determinations *are* subject to meaningful further review even though the Board is unable to change medical-necessity determinations. The Board's authority to review an IMR determination includes the authority to determine whether it was adopted without authority or based on a plainly erroneous fact that is not a matter of expert opinion. (§ 4610.6, subd. (h)(1) & (5).) These grounds are considerable and include reviews of both factual and legal questions.

(*Stevens v. Workers' Comp. Appeals Bd.* (2015) 241 Cal.App.4th 1074, 1100 ("*Stevens*").)

Thus, when a party contests a final IMR decision under section 4610.6(h) or disputes the validity of a repeated RFA for medical treatment previously denied or modified under section 4610(k), or the timeliness of a UR determination pursuant to the strict time limitations of section 4610(i), the Legislature intended the Appeals Board to be the venue in which parties may challenge issues ancillary to the UR/IMR process. The Legislature specifically retained the Board's traditional jurisdiction in this regard when it amended section 4604 to reserve to the Appeals Board jurisdiction over all medical treatment disputes except those issues subject to the IMR process of section 4610.5. And even when the Legislature specified the limited grounds on which a party could challenge an IMR determination, it again designated the Appeals Board as the tribunal to hear and decide those limited appeals. (Lab. Code, § 4610.6(h).) Accordingly, while IMR is the sole avenue for an employee to challenge an otherwise valid, timely UR determination on grounds of medical necessity, the Legislature conferred on the Appeals Board the jurisdiction to hear and decide all ancillary issues attendant to the UR/IMR process.

In addition, the Appeals Board always retains the jurisdiction in the first instance necessary to determine whether it may appropriately exercise jurisdiction over a particular controversy. (*Scott v. I.A.C.* (1937) 9 Cal.2d 315; *Sea World Corp. v. Superior Court* (1973) 34 Cal.App.3d 494.)

The statutory scheme set forth in sections 4604, 4610, and 4610.5 reflects a dispute resolution process that directs unresolved medical necessity disputes to UR and IMR but also reserves to the Appeals Board the jurisdiction to hear and resolve all other controversies related to medical treatment afforded under California's workers' compensation system. The ability of the Appeals Board "upon the request of either party" to make a baseline factual inquiry into whether an RFA validly invokes the UR process, or whether a UR decision validly invokes the IMR process, is an essential and authorized exercise of the jurisdiction afforded to the Appeals Board by the California legislature. (Lab. Code, § 4604.)

Here, we exercise the jurisdiction afforded under sections 4604 and 5304 in two respects. In the first instance, we evaluate the question of whether a contested UR/IMR process was appropriately invoked to address a pending, unresolved question of medical necessity. In addition, as is discussed below, we exercise our jurisdiction to *enforce* the provision of medical treatment that has previously been determined to be medically necessary by a valid UR/IMR process.

II.

The UR process emphasizes speed, accuracy, and finality in medical treatment decisions for employees and employers alike. (*State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (*Sandhagen*) (2008) 44 Cal.4th 230, 241 [73 Cal.Comp.Cases 981].) To the extent that a party disagrees with an otherwise valid UR decision, it would defeat the goals of speed and finality to allow a party to resubmit a disputed treatment request for UR in the hope that a different reviewing physician might reach a different conclusion regarding medical necessity. The repeated submission of the same treatment request to UR would undermine the integrity of the UR process and would result in the type of delay and uncertainty that the Legislature sought to avoid in creating the UR process. (*Id*. at p. 244.)

Accordingly, the Legislature enacted section 4610(k), which provides that a UR decision to modify or deny a treatment recommendation generally remains in effect for 12 months with no further action required by the employer. (Lab. Code, § 4610(k); see Cal. Code Regs., tit. 8, § 9792.9.1(h).) The Legislature provided an explicit exception to the 12-month window where the circumstances surrounding the original UR decision had changed. (Lab. Code, § 4610(k).) In so doing, the Legislature provided for a threshold factual inquiry into whether a change in circumstance created a new question of medical necessity.

In order to determine whether a new question of medical necessity has arisen, section 4610(k) sets forth a specific metric: a "documented change in the *facts* material to the basis of the utilization review decision." (Lab. Code, § 4610(k), italics added.) This standard is applied in all instances where a treating physician seeks to establish that a previously denied or modified treatment request is now justified by an underlying change in the employee's condition that warrants a renewed assessment of the question of medical necessity. The statutory reasoning is clear: when a prior UR process decides a question of medical necessity, the onus is on the party challenging that determination to establish that the facts or circumstances relevant to the original decision have changed, such that there is a new, different question of medical necessity. Thus,

when a valid, timely UR decision denies or modifies a treatment request, an employee may not circumvent the UR decision by resubmitting the same treatment request for another UR unless they can establish a documented change in the facts material to the original UR decision. The determination of whether there has been a change in the facts material to the prior UR decision is made by the Appeals Board. (See, e.g., *United Airlines v. Workers' Comp. Appeals Bd.* (*Van Dyne Parmet*) (2023) 88 Cal.Comp.Cases 989 (writ den.).)

Although 4610(k) applies in instances where the treating physician is seeking additional UR of treatment previously addressed by UR, this same reasoning is applicable in instances where a valid, timely UR decision approves in whole or in part an RFA and the employer is obligated to provide that treatment. Because there is no provision in section 4610.5 or 4610.6 that allows an employer to challenge a UR decision, the employer may not circumvent the original UR decision by resubmitting the same treatment request for another UR unless it can establish a documented change in the facts material to the original UR decision. In other words, the employer may not use a subsequent UR process as a de facto appeal of a prior UR certification determining that a requested treatment is medically necessary unless and until a new question of medical necessity arises.

It is clear that when an employee submits a request for medical treatment because of a change in circumstances, the employee carries the burden of proof to show a change in circumstances. However, if the treatment is already being provided, i.e., it has already been found to be medically necessary, the employee has no reason to "dispute" the decision. In other words, the employee has met their evidentiary burden of establishing that a requested treatment was medically necessary, as evidenced in the affirmative UR certification of that treatment. To the extent that there has been no change in circumstances giving rise to the need for the requested medical treatment, there is no new question of medical necessity.

Here, the February 16, 2021 UR decision certified home health care services as medically necessary but modified the quantity of home health care services to be provided from seven days per week to five days per week. (Ex. 1, UR Determination, dated February 16, 2021, at p. 5.) Based on the UR decision to certify the modified treatment as medically necessary, defendant was obligated to provide the medical treatment.

Applicant thereafter appealed the UR decision to modify the RFA. However, IMR upheld the UR decision on April 12, 2021. (Ex. E, IMR Determination, dated April 12, 2021, at p. 1.) Of

note, the IMR decision specifically declined to disturb the provision of six hours of home health care services, five days per week as set forth in the modified UR certification, noting that the home health care treatment had been authorized and was therefore not subject to review. (*Id.* at p. 3.) In the absence of a successful appeal to IMR, the February 16, 2021 UR decision is binding and enforceable. (Lab. Code, § 4610.5.)

Insofar as Dr. Miller's subsequent March 16, 2021 RFA requested the same treatment as the February 16, 2021 RFA, i.e., home health care services of six hours per day, seven days per week, section 4610(k) provides that the earlier February 16, 2021 UR decision to modify the home health care "shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician … for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision." (Lab. Code, § 4610(k).) Notwithstanding the potential applicability of section 4610(k), we further observe that the March 16, 2021 RFA in evidence does not indicate there has been a change in the facts material to the basis of the prior UR decision. (Ex. 8, Request for Authorization, dated March 16, 2021, at p. 1.) Accordingly, the March 16, 2021 RFA does not present a new, unresolved question of medical necessity. In the absence of a pending, unresolved question of medical necessity, the UR/IMR process is inapplicable, and the earlier February 16, 2021 UR decision authorizing home health care services remains in effect.

We thus return to the February 16, 2021 UR decision which modified the PTP's request from seven days of weekly home health care services to five days of weekly home health care services. (Ex. 1, Utilization Review Determination, dated February 16, 2021, at p. 1.) The physician reviewer's "Clinical Rationale" discussion states:

> This is a request for Home health care 6 hours per day for 7 days a week for 12 weeks. CA-MTUS 2017 Initial Approaches to Treatment Guideline states, Home healthcare is selectively recommended on a short-term basis following hospitalization, major surgical procedures, to prevent (re)hospitalization, to overcome deficits in activities of daily living, and/or to provide nursing, therapy and/or supportive care services for those who would otherwise require inpatient care. It is notable that this individual has over 2 years status post surgery. As the guidelines would indicate that home health services or for short-term basis. In addition, the ODG guidelines also indicate that home health services or to be considered short-term basis. The assessment reviewed within the documentation of the significance of issues in regards to this individual's condition. Noted is

> that she is blind, in a wheelchair with poor mobility described. It is unclear as to whether the condition is related to the industrial injury with a hip fracture or whether this is a degeneration of her condition because she is obese, diabetic, significant medical comorbidities. The continuation of home health services on a near constant basis is not medically necessary for the industrial injury. There is also no indication that from the documentation reviewed that this would resolve itself within a period of 12 weeks. The consideration for home health services modified to 90 hours, 6 hours a day 5 days a week giving that her son works and therefore should be capable of helping her on weekends when he is not working. In addition, there should be some other source of permanent health care given that her condition is more of a prominent condition rather than temporary. Therefore it is necessary to provide some assistance in the interim until a more specific, permanent solution is found for her condition.

(*Id.* at pp. 4-5.)

Unfortunately, the reviewing physician's discussion is not a model of clarity. We note initially that the physician's statement that because applicant's "son works and therefore should be capable of helping her on weekends when he is not working" is speculative, unsupported in the factual and medical record, and legally suspect. Defendant has an affirmative statutory duty to provide "[m]edical, surgical … and hospital treatment, including nursing … which is reasonably required to cure or relieve from the effects of the injury …." (Lab. Code, § 4600.) The availability of a family member to provide care that has been determined to be medically necessary does not relieve the employer of its statutory obligation to provide those services or to reimburse the cost of their provision. (*Henson v. Workmen's Comp. Appeals Bd.* (1972) 27 Cal.App.3d 452, 457 [37 Cal.Comp.Cases 564]; *McCoy v. I.A.C*. (1966) 64 Cal. 2d 82, 86 [31 Cal.Comp.Cases 93].) Nor does the reviewing physician explain how he arrived at a figure of 90 *hours* of aggregate home health care services. PTP Dr. Miller's original RFA sought authorization for 12 weeks of home health care services or approximately 90 *days*, and the UR physician's discussion of reducing Dr. Miller's requested allotment was limited to the assumed availability of applicant's son to provide care on weekends. We are unable to identify *any* rationale for the decision to modify the RFA for home health care services to 90 hours, the equivalent of approximately three weeks of home health care services at 30 hours per week (six hours per day, five days per week).

We also observe that irrespective of the presence of nonindustrial conditions, section 4600 requires that a defendant provide medical treatment "reasonably required to cure or relieve the injured worker from the effects of his or her injury." (*Granado v. Workmen's Comp. Appeals Bd.* (1968) 69 Cal.2d 399, 406 [33 Cal.Comp.Cases 647, 652] ["So long as the treatment is reasonably

required to cure or relieve from the effects of the industrial injury, the employer is required to provide the treatment"].) Thus, it is well settled that an employer will be liable even for the cost of treatment for a non-industrial condition, if that treatment is reasonably required to cure or relieve the effects of the industrial injury. (*Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd.* (*Bolton*) (1983) 34 Cal.3d 159, 165-166 [48 Cal.Comp.Cases 566, 570].) It is for this reason that "treatment for nonindustrial conditions may be required of the employer where it becomes essential in curing or relieving from the effects of the industrial injury itself." (*Granado*, *supra*, 69 Cal.2d at p. 406.) Thus, the UR physician reviewer's concerns about the presence of nonindustrial comorbidities does not, without more, preclude defendant's liability for the requested treatment so long as it is medically necessary to cure or relieve from the effects of applicant's industrial injury. (Lab. Code, § 4600; *Granado*, *supra*, 69 Cal.2d 399; *Bolton*, *supra*, 34 Cal.3d 159.)

The UR physician observes that inasmuch as the "guidelines" provided under the MTUS and the ODG standards address the need for home health care services in the context of acute and subacute medical conditions rather than chronic or permanent conditions, neither metric is a good fit for applicant's condition and the services requested by the PTP. The UR physician reviewer observes that "there should be some other source of permanent health care given [applicant's] condition is more of a prominent (sic) condition rather than temporary." (Ex. 1, UR Determination, dated February 16, 2021, at p. 5.) Accordingly, the physician reviewer certified a modified level of weekly home health care services, stating that "it is necessary to provide some assistance in the interim until a more specific, permanent solution is found for her condition." (*Ibid*.)

Defendant's Petition acknowledges the UR physician's statement attesting to the need for ongoing interim services but contends "there is nothing implicit in this decision which places the burden of finding that solution on defendants." (Petition, at p. 6:2.) We disagree.

In *Ramirez v. Workers' Comp. Appeals Bd.* (1970) 10 Cal.App.3d 227 [35 Cal.Comp.Cases 383] (*Ramirez*), the court of appeal observed that:

> Upon notice or knowledge of a claimed industrial injury an employer has both the right and *duty to investigate the facts* in order to determine his liability for workmen's compensation, but he must act with expedition in order to comply with the statutory provisions for the payment of compensation which require that he *take the initiative in providing benefits*. He must seasonably offer to an industrially injured employee that medical, surgical or hospital care which is reasonably required to cure or relieve from the effects of the industrial injury.

(*Ramirez, supra*, at p. 234, italics added.)

In *United States Cas. Co. v. I.A.C.* (*Moynahan*) (1954) 122 Cal.App.2d 427, [19 Cal.Comp.Cases 8], the court similarly states:

> Section 4600 of the Labor Code places the responsibility for medical expenses upon the employer when he has knowledge of the injury….The duty imposed upon an employer who has notice of an injury to an employee is not … the passive one of reimbursement but the active one of offering aid in advance and of making whatever investigation is necessary to determine the extent of his obligation and the needs of the employee.

(*Moynahan, supra*, at p. 435.)

In *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 Cal.Comp.Cases 682 (Appeals Board en banc) (*Neri Hernandez*), we reiterated that "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." (*Neri Hernandez, supra*, at p. 695; see also *Bolton*, *supra*, 34 Cal.3d at p. 65.)

We also observe that defendant has a regulatory duty to conduct a reasonable and good faith investigation to determine whether benefits are due. Specifically, AD Rule 10109 provides, in relevant part:

> (a) [A] claims administrator must conduct a reasonable and timely investigation upon receiving notice or knowledge of an injury or claim for a workers' compensation benefit.
>
> (b) A reasonable investigation must attempt to obtain the information needed to determine and timely provide each benefit, if any, which may be due the employee.
>
> > (1) The administrator may not restrict its investigation to preparing objections or defenses to a claim, but must fully and fairly gather the pertinent information ... The investigation must supply the information needed to provide timely benefits and to document for audit the administrator's basis for its claims decisions. The claimant's burden of proof before the Appeal Board does not excuse the administrator's duty to investigate the claim.
> >
> > (2) The claims administrator may not restrict its investigation to the specific benefit claimed if the nature of the claim suggests that other benefits might also be due.

> (c) The duty to investigate requires further investigation if the claims administrator receives later information, not covered in an earlier investigation, which might affect benefits due.
>
> …
>
> (e) Insurers, self-insured employers and third-party administrations shall deal fairly and in good faith with all claimants, including lien claimants.

(Cal. Code Regs., tit. 8, § 10109.)

Thus, and upon reasonable notice of the need to treatment necessary to cure or relieve from the effects of industrial injury, the employer has an affirmative obligation to promptly investigate the facts in order to determine its liability for workers' compensation and take the initiative in providing benefits. (*Ramirez, supra,* 10 Cal.App.3d at p. 234.) The duty to seasonably investigate is triggered upon notice that home health care or home modification services may be needed or are being provided. (*Neri Hernandez, supra,* 79 Cal.Comp.Cases at p. 695.)

Here, the record clearly establishes that applicant's activities of daily living are significantly compromised through a combination of industrial and nonindustrial conditions; that applicant's industrial injury is contributing in part to the need for home health care services; and that the reviewing UR physician has endorsed the need for interim services until such time as a permanent solution addressing applicant's home health care needs can be found. Upon receipt of the February 16, 2021, defendant had an affirmative obligation to promptly investigate the facts of applicant's condition and circumstance and to take appropriate proactive action to provide reasonable benefits. (Ex. 1, UR Determination, dated February 16, 2021, at p. 1.) However, the record reflects no such prompt investigation or inquiry into applicant's home health care needs.

We thus find defendant's contention that it was not required to take any further action to investigate whether benefits were needed to help cure or relieve from the effects of applicant's industrial injuries to be unpersuasive. Rather, defendant was required to "take the initiative in providing benefits," and to "seasonably offer to an industrially injured employee that medical, surgical or hospital care which is reasonably required to cure or relieve from the effects of the industrial injury." (*Moynahan, supra*, at p. 435.) The UR/IMR process does not relieve the defendant of its longstanding obligation to take reasonable steps to determine and proactively provide the medical treatment required under section 4600(a).

In summary, we believe the dispute over the provision of applicant's home health care services must be resolved through *enforcement* of the February 16, 2021 UR decision. The Appeals Board's jurisdiction to hear and decide this issue is not a determination of the medical necessity of the requested medical treatment, but rather an exercise of the jurisdiction afforded under section 4604 to enforce the award of medical treatment that has been determined to be medically necessary through a valid UR/IMR process. Moreover, to the extent that the PTP's subsequent March 16, 2021 RFA was subject to the prohibitions of section 4610(k) and in any event did not present a new and unresolved question of medical necessity, we conclude that the March 16, 2021 RFA did not present a valid basis upon which to invoke the UR/IMR process. (Ex. 1, UR Determination, dated February 16, 2021, at p. 5.)

In this matter, defendant submitted PTP Dr. Miller's RFA for home health care services to external UR, and the resulting February 16, 2021 UR decision modified the request and certified interim medical care in the form of weekly home health care services until such time as a permanent solution could be found. Applicant's appeal to IMR for the original levels of requested services was denied. Because the February 16, 2021 UR decision made clear that interim home health care services would be necessary until a permanent solution could be found to address applicant's home health needs, and because the record reflects no efforts to reach such resolution, we agree with the WCJ's decision to enforce the February 16, 2021 UR decision.

However, we also observe that the March 16, 2021 RFA did not present a previously unresolved question of medical necessity, and as such, we do not concur with the WCJ's burden shifting analysis. Accordingly, we will amend Finding of Fact No. 3 to reflect that the UR decision of February 16, 2021 determined that the nature of applicant's condition requires the provision of continued home health care services until a more specific, permanent solution is found. We will then amend the Order to reflect that defendant must continue to provide the specified home health care services, six hours per day, five days per week, until such time as the parties can demonstrate reasonable efforts to identify and implement a permanent solution to applicant's need for home health care services.

For the foregoing reasons,

IT IS ORDERED, as the Decision After Reconsideration of the Workers' Compensation Appeals Board, that the November 9, 2021 Findings and Orders is **AFFIRMED**, except that it is **AMENDED** as follows:

FINDINGS OF FACT

***

3. The February 16, 2021 Utilization Review determination establishes that the nature of applicant's condition requires the provision of continued home health care services until a more specific, permanent solution is found.

***

ORDER

IT IS ORDERED that home care for six hours a day, five days a week be provided to applicant until such time as either of the parties can demonstrate reasonable efforts taken to identify and implement a permanent solution to applicant's need for home health care services.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSEPH V. CAPURRO, COMMISSIONER

I CONCUR,

/s/ JOSÉ H. RAZO, COMMISSIONER

/s/ KATHERINE A. ZALEWSKI, CHAIR

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

September 23, 2026

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

VIVIANA ELIZABETH TABOADA
GLAUBER, BERENSON & VEGO
INGER, WEINBERG & GEVOGLANYAN

SAR/abs

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