WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

JORGE OROZCO, ***Applicant,*** **vs.** **SOUTHLAND FRAMERS; STATE COMPENSATION INSURANCE FUND,** ***Defendants.***	**Case No. ADJ4611519** **(Los Angeles District Office)** **OPINION AND DECISION AFTER RECONSIDERATION**

We granted defendant's Petition for Reconsideration to further study the factual and legal issues in this case. This is our Opinion and Decision After Reconsideration. Defendant sought reconsideration of the Findings and Award issued by a workers' compensation administrative law judge (WCJ) on June 29, 2015, wherein the WCJ found that applicant, while employed as a carpenter on September 7, 2001, sustained industrial injury to his back, neck, and head, causing a need for further medical treatment. In the Opinion on Decision, the WCJ found that defendant did not conduct timely utilization review (UR) of the May 9, 2012 and November 25, 2014 requests for authorization (RFAs) for home health care services. The WCJ also found that defendant was liable for home health care services after May 1, 2012, up to 12 hours a day, seven days a week. The WCJ found there was substantial medical evidence in the record to justify the requested home health care services. The WCJ ordered development of the record on the home health care services provided to applicant prior to his injury, and the services provided to him since May 1, 2012.

Defendant contended that the WCJ erred by awarding home health care services, arguing that she should not have found that the UR determination was untimely. Defendant argues that the medical report relied on did not specify the treatment guideline supporting the request, that the number of hours of home health care exceeds the number of hours recommended by Medicare, and that there were no findings

regarding any services that had been performed by member of applicant's household prior to his industrial injury.

Applicant filed an Answer. We received a Report and Recommendation on Petition for Reconsideration (Report) from the WCJ in response to defendant's Petition for Reconsideration, which recommended that the Petition be granted as this is a recurring issue of importance to the workers' compensation community.

We have reviewed the record and have considered the allegations of the Petition for Reconsideration, the Answer, and the contents of the WCJ's Report, and we now issue our decision after reconsideration. For the reasons set forth herein and by the WCJ in the Report, we affirm the WCJ's June 29, 2015 decision finding that defendant is liable for home health care services, up to 12 hours a day, seven days a week after May 1, 2012, and that the record be further developed regarding all dates that services were provided. We amend the decision to add a finding that defendant did not conduct timely UR of applicant's RFAs received on May 9, 2012 and November 25, 2014.

RELEVANT FACTS

Applicant, while employed as a carpenter on September 7, 2001, sustained industrial injury to his back, neck, and head, and filed three claims for benefits. This case (ADJ4611519) proceeded to trial on June 9, 2015. The issues were framed as follows:

1. Whether State Compensation Insurance Fund has timely obtained a utilization review determination of Applicant's request for home health care assistance.
2. Whether Applicant is currently entitled to home health care.
3. Whether Applicant is entitled to home health care since February 20, 2012.

Applicant's primary treating physician, Lawrence Miller, M.D., Board certified in pain management, anesthesiology, and internal medicine, examined applicant on February 20, 2012 and issued a report titled "Supplementary Report/Request for Authorization," noting that "[t]he patient is in need of home care assistance." (Applicant's Ex. 11.) Dr. Miller noted that applicant was ambulating with a wheeled walker and that his wife was providing continuous home care services for him.

In his February 20, 2012 report, Dr. Walker wrote as follows:

> Patient requires home care assistance. He is a candidate at least eight hours a day,

five days a week for home care assistance to assist with bathing, dressing, food preparation, laundering, and cleaning. (Applicant's Ex. 11, p. 2.)

On May 17, 2013, the agreed medical examiner (AME), Jeffrey A. Berman, M.D., issued a report, noting that on April 30, 2012, Dr. Miller again requested home health care services for bathing, dressing, food preparation, laundering, and cleaning. (Appeals Board Ex. X, p. 5.) The AME noted that Dr. Miller had increased the requested home health care to 12 hours per day, seven days a week. (*Id.*, pp 15-16.)

On May 15, 2012, Ted Tanzer, M.D., of Anthem Workers' Compensation, and Dr. Miller agreed that, as part of the UR process, "a relatively expedited RN evaluation should be done to assess the patient's needs." (Defendant's Ex. C.)

On July 25, 2014, 26 months after this agreement, the nurse case manager, Grecia Zamudio, R.N., performed the evaluation. She found applicant "requires maximum assistant with the majority of his activities of daily living." (Applicant's Ex. 4, p. 4.) Ms. Zamudio recommended home health care assistance 12 hours per day, seven days a week to assist applicant with nutritional meal preparation, grocery shopping, grooming, hygiene, transfers into and out of the shower, bathing, dressing, transportation services and assistance in and out of vehicles, home cleaning, laundry, opening medication bottles, and verbal reminders to take medications. The nurse case manager report was sent to Dr. Miller and SCIF. Dr. Miller reviewed nurse case manager's report and adopted its recommendations in his own October 13, 2014 report. (Applicant's Ex. 3.)

On October 17, 2014, Dr. Miller submitted an RFA to defendant.

On December 9, 2014, the RFA was denied on the grounds that the Medicare Benefits Manual indicates "services should be part-time and not exceeding 28 hours per week, and authorization should not be made if these services are regularly performed by a member of the patient's household." (Defendant's Ex. A, p. 4.)[1]

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[1] With respect to this document, the WCJ noted in her Report, "Exhibit A appears to be incomplete as there is no signature and no proof of service, and it appears that SCIF submitted "pages 2-7 of a 17 page document."

The UR determination indicates that the RFA was received on November 25, 2014, and the decision to deny was made on December 8, 2014. On December 9, 2014, defendant notified Dr. Miller of the denial.

On June 29, 2015, the WCJ issued the disputed decision, awarding applicant home health care services up to 12 hours a day, seven days a week from May 1, 2012.

DISCUSSION

A. The Utilization Review Denials Were Untimely and the WCAB Has Jurisdiction to Determine the Medical Necessity of the Requests for Home Health Care Services.

In the instant Petition, defendant does not address the timeliness of the UR denials. Defendant argues that it is not at fault for the 26-month delay in conducting an evaluation by the nurse case manager. We agree with the WCJ that the WCAB has jurisdiction to address the medical necessity of the requests for home health care services because the UR determinations were untimely.

In 2012, former Labor Code[2] section 4610(g)(1) provided that,

> Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

In this matter, Dr. Miller issued an RFA on May 9, 2012 requesting authorization for home health care 12 hours a day, seven days a week, for six weeks. Defendant acknowledged receipt of the May 9, 2012 RFA and issued a delay letter on May 15, 2012. (Applicant's Ex. 10.) Also on May 15, 2012, Dr. Miller and Dr. Tanzer agreed that "a relatively expedited RN evaluation should be done to assess the patient's needs." (Defendant's Ex. C.)

Here, the initial delay was timely. However, no UR determination issued within the statutory period, "14 days from the date of the medical treatment recommendation by the physician." (Former § 4610(g)(1).)

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

After the nurse evaluation was completed on July 25, 2014, Dr. Miller again submitted an RFA for home health care services, 12 hours a day, seven days a week, dated and served October 17, 2014. (Applicant's Ex. 2.) The RFA package served included "medical justification per UR guidelines." The record does not clarify whether the medical justification was Dr. Miller's October 13, 2014 report. (Applicant's Ex. 3.)

Defendant's UR determination indicates that it received the October 17, 2014 RFA on November 25, 2014, and that the decision to deny the request was made on December 8, 2014. On December 9, 2014, CID Management, on behalf of defendant, notified Dr. Miller that the request was denied because the Medicare Benefits Manual indicates, "services should be part-time and not exceeding 28 hours per week, and authorization should not be made if these services are regularly performed by a member of the patient's household." (Defendant's Ex. A, p. 4.)

Whether a specific date constitutes a normal business day for purposes of determining the timeliness of UR is a legal question that depends on application of the relevant statutory and regulatory language. Section 4600.4 provides the method for determining whether a given day is to be regarded as a "normal business day" for purposes of UR decisions. Pursuant to section 4600.4, Civil Code sections 7 and 9, and Government Code section 6700, the day after Thanksgiving is not excluded from being treated as a "normal business day." (*Cal. Dept. of Corrections v. Workers' Comp. Appeals Bd. (Gomez)* (2018) 83 Cal.Comp.Cases 530, 534 (writ den.).)

In 2014, section 4610(g) provided that prospective or concurrent decisions shall be made within five working days unless additional information was requested. November 25, 2014, was a Monday. Thanksgiving Day (November 27, 2014) and the weekend (November 29 and 30, 2014) are excluded from the calculation of five working days. To be timely, the UR determination should have been communicated by December 3, 2014, the following Wednesday.

In this matter, the RFA was received no later than November 25, 2014. Former AD Rule 9792.9.1(e)(3), in effect at the time of defendant's UR determination, provided in pertinent part, "[A] decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or

electronic mail." (Former Cal. Code Regs., tit. 8, § 9792.9.1(e)(3).

Thus, any UR determination regarding the November 25, 2014 RFA must have been communicated to the requesting physician by December 4, 2014. (*Bodam v. San Bernardino Co./Dept. of Social Services* (2014) 79 Cal.Comp.Cases 1519, 1522 (significant panel decision.)[3] There is no evidence that the UR determination was communicated to Dr. Miller by telephone, facsimile, or electronic means within 24 hours. The record reflects that defendant's UR notified Dr. Miller of the determination on December 9, 2014, nine working days after receipt of the RFA on November 25, 2014, and four days after the statutory time period lapsed.

In our decision in *Dubon v. World Restoration, Inc.,* (2014) 79 Cal.Comp.Cases 1298 (Appeals Board en banc) (*Dubon II*), we stated that if a UR denial is untimely, the determination of medical necessity of the disputed medical treatment may be made by the WCAB based on substantial medical evidence consistent with section 4604.5. (See also *State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (Sandhagen)* (2008) 44 Cal.4th 230, 240–241 [73 Cal.Comp.Cases 981].)

The UR denials were untimely. Therefore, the Board has jurisdiction to determine the medical necessity of the requests for home health care services.

B. Substantial Medical Evidence Supports the Award of Home Health Care Services

An industrially injured worker is entitled, at his/her employer's expense, to medical treatment that is reasonably required to cure or relieve the effects of the industrial injury. (Lab. Code, § 4600(a).) Home health care services, including housekeeping services, have long been held to be subject to reimbursement under section 4600 as medical treatment reasonably required to cure or relieve from the effects of the injury, if there is a medical recommendation or prescription that certain housekeeping

[3] Significant panel decisions are not binding precedent in workers' compensation proceedings; however, they are intended to augment the body of binding appellate court and en banc decisions and, therefore, a panel decision is not deemed "significant" unless, among other things: (1) it involves an issue of general interest to the workers' compensation community, especially a new or recurring issue about which there is little or no published case law; and (2) all Appeals Board members have reviewed the decision and agree that it is significant. (See *Elliott v. Workers' Comp. Appeals Bd.* (2010) 182 Cal. App. 4th 355, 361, fn. 3 [105 Cal. Rptr. 3d 760, 75 Cal. Comp. Cases 81]; *Larch v. Workers' Comp. Appeals Bd.* (1999) 64 Cal. Comp. Cases 1098, 1099–1100 (writ den.); 25 Cal. Workers' Comp. Rptr. 197 [News Brief, August 1997].)

services be performed, i.e., that there is a "demonstrated medical need" for such services. (*Smyers v. Workers' Comp. Appeals Bd.* (1984) 157 Cal.App.3d 36, 42.) Where there is no timely UR decision subject to IMR, the issue of medical necessity must be determined by the WCAB. (§§ 4604, 5300.)

The WCJ wrote in his Report as follows:

> SCIF denied home health care services because the Medicare Benefits Manual limits services to 28 hours per week and because the Medicare Benefits Manual provides that authorization should not be given if the services are being provided by a member of the patient's household. (Exhibit A, p. 4.) The Medicare Benefits Manual should not be used to determine the issue. Labor Code section 4610.5 sets out a hierarchy of resources to be used in determining whether a particular modality is appropriate. The MTUS [Medical Treatment Utilization Standards] is at the top of that list. Contrary to SCIF's assertion, the Chronic Pain Medical treatment Guidelines do address home health care services on page 51. (Report, p. 5.)

The Labor Code makes it clear that rules related to the scope of necessary medical care are to be determined under the workers' compensation law, not in accordance with Medicare coverage rules. Former and current section 5307.1(a)(2)(A)(i), states: "Employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600." In addition, the fee schedule statute evidences the legislative intent that the Medicare rules not be adopted in their entirety. Former and current section 5307.1(a)(2)(B), states: "The official medical fee schedule shall include payment ground rules that differ from Medicare payment ground rules, including, as appropriate, payment of consultation codes and payment evaluation and management services provided during a global period of surgery."

In this case, the WCAB has authority to determine the issue of medical necessity. A decision regarding the medical necessity of the treatment request must be supported by substantial evidence in light of the entire record. (*Dubon II, supra*; *Lamb v. Workers' Comp. Appeals Bd.* (1974) 11 Cal. 3d 274 [113 Cal. Rptr. 162, 520 P.2d 978, 39 Cal. Comp. Cases 310]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal. 3d 627 [83 Cal. Rptr. 208, 463 P.2d 432, 35 Cal. Comp. Cases 16].) The Appeals Board has stated, "a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it

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must set forth reasoning in support of its conclusions." (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 620-621 [Appeals Board en banc].)

Our review of the record finds that the medical opinion of Dr. Miller, upon which the WCJ relied, constitutes substantial evidence. In multiple reports, Dr. Miller explains his reasoning for concluding that applicant's industrial injury caused his need for home health care services. He reviewed the July 25, 2014 nurse evaluation and incorporated its recommendations. The nurse evaluation and Dr. Miller's reports are consistent with his opinion that applicant needs home health care, 12 hours a day, seven days a week to assist with nutrition, grooming, hygiene, transportation, house cleaning, and transfers. As applicant's treating physician, Dr. Miller had a complete history of applicant's activities and limitations, and took these into account when assessing applicant's need for home health care services. Dr. Miller's reports and the medical evidence establish that applicant was "homebound" and unable to leave home or to perform activities of daily living without help, i.e., the use of a walker. Here, after observing applicant's mobility impairment, Dr. Miller opined that there was a medical necessity for applicant to be provided with home health care. Dr. Miller's opinion provided the WCJ with substantial evidence to support her findings, and she has properly relied on Dr. Miller's reporting.

We note that in *Stevens v. Workers' Comp. Appeals Bd.* (2015) 241 Cal.App.4th 1074 [80 Cal.Comp.Cases 1262), the Court of Appeal found that the WCAB has authority to grant an IMR appeal and set aside a determination that relies upon an incorrect treatment guideline, such as the incorrect MTUS. The reasoning is instructive because in this matter, the UR applied an incorrect guideline. The court stated that such an error can be described both as an action "in excess of the administrative director's powers" under section 4610.6(h)(1), and under section 4610.6(h)(5) as a "mistake of fact [as] a matter of ordinary knowledge… and not a matter that is subject to expert opinion." The WCAB found that the 2009 MTUS is an invalid regulation and is void ab initio. (*Stevens, supra*, 2017 Cal. Wrk. Comp. P.D. LEXIS 299.)

On July 28, 2016, the AD revised the "Chronic Pain" portion of the MTUS, including the regulation pertaining to home health care services. The 2016 MTUS, while it does not apply to the timeline presented here, provides guidance and a framework for physicians to make clear the "what and

why" of a prescription for home health care services, the specificity required, and the types of services permitted. If a requested treatment is not addressed in the MTUS, it may not be summarily denied; the IMR reviewer should apply the hierarchical framework in section 4610.5(c)(2) and AD rules 9792.21 and 9792.21.1 to determine the medical necessity of the request.

> [T]he denial of a particular treatment request on the basis that the treatment is not permitted by the MTUS would be reviewable on the ground that the treatment actually is permitted by the MTUS. An IMR determination denying treatment on this basis would have been adopted without authority and would thus be reviewable. (*Stevens v. Outspoken Enterprises Inc.* (May 19, 2017, ADJ1526353) [2017 Cal. Wrk. Comp. P.D. LEXIS 299].)

In her Report, the WCJ wrote, "section 4610.5 sets out a hierarchy of resources to be used in determining whether a particular modality is appropriate. The MTUS are at the top of that list." (Report, p. 5.) The record contains compelling evidence regarding applicant's medical necessity for home health care services to cure or relieve from the effects of his industrial injury.

Based on the provisions of sections 4600, 4603.2, and 5307.8, and the recommendation of the treating physician and the nurse evaluator, the WCJ properly determined that the WCAB has jurisdiction to determine medical treatment issues and that Dr. Miller's reporting constitutes substantial evidence. The WCJ correctly found that applicant is in need of home health care services on an industrial basis, and that the record should be further developed with respect to the services provided to applicant prior to his injury and since May 1, 2012.

Accordingly, based on the record and for the reasons stated herein, as our Decision After Reconsideration, we amend the June 29, 2015 Findings and Award to add a finding that defendant's UR determinations were untimely, and affirm the decision in all other respects.

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For the foregoing reasons,

IT IS ORDERED, as the Decision After Reconsideration of the Workers' Compensation Appeals Board, that the June 29, 2015 Findings and Award is **AFFIRMED, EXCEPT** that it is **AMENDED** to read as follows:

FINDINGS OF FACT

* * *

5. Defendant did not conduct timely utilization review of applicant's requests for authorization received on May 9, 2012 and November 25, 2014.

WORKERS' COMPENSATION APPEALS BOARD

CHAIR

KATHERINE ZALEWSKI

I CONCUR,

MARGUERITE SWEENEY

DEIDRA E. LOWE

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

JAN 31 2019

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

JORGE OROZCO
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STATE COMPENSATION INSURANCE FUND

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WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

JORGE OROZCO, ***Applicant,*** **vs.** **SOUTHLAND FRAMERS; STATE COMPENSATION INSURANCE FUND,** ***Defendants.***	**Case No. ADJ4611519 (POM 0258053)** **(Los Angeles District Office)** **OPINION AND ORDER GRANTING PETITION FOR RECONSIDERATION**

Reconsideration has been sought by defendant with regard to the decision filed on June 29, 2015.

Taking into account the statutory time constraints for acting on the petition, and based upon our initial review of the record, we believe reconsideration must be granted to allow sufficient opportunity to further study the factual and legal issues in this case. We believe that this action is necessary to give us a complete understanding of the record and to enable us to issue a just and reasoned decision. Reconsideration will be granted for this purpose and for such further proceedings as we may hereafter determine to be appropriate.

For the foregoing reasons,

IT IS ORDERED that Reconsideration is **GRANTED.**

IT IS FURTHER ORDERED that pending the issuance of a Decision After Reconsideration in the above case, all further correspondence, objections, motions, requests and communications *relating to the petition* shall be filed only with the Office of the Commissioners of the Workers' Compensation Appeals Board at either its street address (455 Golden Gate Avenue, 9th Floor, San Francisco, CA 94102) or its Post Office Box address (P.O. Box 429459, San Francisco, CA 94142-9459), and shall *not* be submitted to the district office from which the WCJ's decision issued or to any other district office of the Workers' Compensation Appeals Board, and shall *not* be e-filed in the Electronic Adjudication

Management System (EAMS). Any documents relating to the petition for reconsideration lodged in violation of this order shall neither be accepted for filing nor deemed filed.

All trial level documents not related to the petition for reconsideration shall continue to be e-filed through EAMS or, to the extent permitted by the Rules of the Administrative Director, filed in paper form.[1] If, however, a proposed settlement is being filed, the petitioner for reconsideration should promptly notify the Appeals Board because a WCJ cannot act on a settlement while a case is pending before the Appeals Board on a grant of reconsideration. (Cal. Code Regs., tit. 8, § 10859.)

WORKERS' COMPENSATION APPEALS BOARD

Anne Schmitz

DEPUTY ANNE SCHMITZ

I CONCUR,

MARGUERITE SWEENEY

Deidra E. Lowe

DEIDRA E. LOWE

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

SEP 15 2015

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

JORGE OROZCO
SOLOV & TEITELL
STATE COMPENSATION INSURANCE FUND

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[1] Such trial level documents include, but are not limited to, declarations of readiness, lien claims, trial level petitions (e.g., petitions for penalties, deposition attorney's fees), stipulations with request for award, compromise and release agreements, etc.)

STATE OF CALIFORNIA
Division of Workers' Compensation
Workers' Compensation Appeals Board

CASE NUMBER: ADJ4611519

JORGE OROZCO	**-vs.-**	**DECOREATIVE SPECIALIST; STATE COMPENSATION INSURANCE FUND**

WORKERS' COMPENSATION ADMINISTRATIVE LAW JUDGE: **Anne J. Horelly**

DATE: **August 4, 2015**

REPORT AND RECOMMENDATION

State Compensation Insurance Fund, workers' compensation carrier for Southland Framers, (SCIF) has filed a timely verified petition for reconsideration of the Findings and Award issued June 29, 2015. SCIF contends that the Workers' Compensation Judge (WCJ) abused her power and authority in determining that the utilization review determination issued 31 months after the initial request was untimely and in awarding home health care services when the medical report relied upon did not specify the treatment guideline supporting the request; the number of hours requested exceeds the number of hours recommended by Medicare; and, there was no finding of what services had been regularly performed by a member of the applicant's household prior to his industrial injury. Applicant has not yet filed an answer. It is recommended that reconsideration be granted as this is a recurring issue of importance to the workers' compensation community.

STATEMENT OF FACTS

Jorge Orozco has filed three claims for workers' compensation benefits. This matter proceeded to trial on only one of those claims, the specific injury occurring September 17, 2001. The issue submitted was whether applicant is entitled to home health care services beginning February 20, 2012.

The primary treating physician, Lawrence Miller, M.D., is Board certified in Pain Management, Anesthesiology and Internal Medicine. Dr. Miller examined Mr. Orozco on February 20, 2012 and issued a report captioned "Supplementary Report/Request for Authorization". (Applicant Exhibit 11.) On page two of his report, Dr. Miller states:

> Patient requires home care assistance. He is a candidate at least eight hours a day, five days a week for home care assistance to assist with bathing, dressing, food preparation, laundering, and cleaning.

On April 30, 2012, Dr. Miller again evaluated Mr. Orozco and again requested home health care services, including assistance with bathing, dressing, food preparation, laundering and cleaning. The report was not submitted as an exhibit but the report was reviewed by the Agreed Medical Examiner (hereinafter "AME"). (Board Exhibit X, p. 5.) The AME noted that the amount of services was increased from 8 hours per day to up to 12 hours per day and from 5 days per week to 7 days per week. (*Id.*, pgs. 15-16.)

On May 15, 2012, Ted Tanzer M.D., of Anthem Workers' Compensation, spoke with Dr. Miller regarding the requested services as part of the utilization review process. Dr. Tanzer and Dr. Miller agreed "that a relatively expedited RN evaluation should be done to assess the patient's needs." (Defendant Exhibit C.) The RN evaluation was performed on July 25, 2014, twenty–six months later. (Applicant Exhibit 4.) Registered Nurse Grecia Zamudio determined that applicant "requires maximum assistance with the majority of his activities of daily living." (*Id.*, p. 4.) She

recommended assistance 12 hours per day, 7 days per week to assist with nutritional meal preparation, grocery shopping, grooming, hygiene, transfers into and out of the shower, bathing, dressing, transportation services and assistance transferring in and out of vehicle, home cleaning services, laundry tasks, assistance opening medication bottles and verbal reminders to take medications.

The Nurse Case Management report was sent to Dr. Miller and SCIF. Dr. Miller reviewed the report and adopted the nurse's recommendations. (Applicant Exhibit 3.) Dr. Miller again submitted a Request for Authorization (RFA) which was mailed to SCIF on October 17, 2014. (Applicant Exhibit 2.) On December 9, 2014, CID Management notified Dr. Miller that the request for home health care services was denied because the Medicare Benefits Manual indicates "services should be part-time and not exceeding 28 hours per week, and authorization should not be made if these services are regularly performed by a member of the patient's household." (Defendant Exhibit A, p.4.[1]) The utilization review determination (hereinafter "URD") indicates that the RFA was received on November 25, 2014 and that the decision to deny was made on December 8, 2014.

WAS THE UTILIZATION REVIEW DETERMINATION TIMELY?

In 2012, Labor Code section 4610(g)(1) provided that prospective reviews were to be completed within five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In this case, the RFA dated May 9, 2012 is the first request that applicant has proven was received by SCIF. The decision to delay was made and communicated on May 15, 2012, five working days later. The delay was timely. The delay was not followed by a URD within the 14-day window. The utilization review determination was untimely.

[1] Exhibit A appears to be incomplete as there is no signature page and no proof of service. The copy submitted contains facsimile notations at the top and on the left-side of the document. The notations suggest that SCIF submitted pages 2-7 of a 17 page document.

The agreement to have the applicant's needs assessed by an RN in a "relatively expedited" manner is a modification to the request for authorization. SCIF documented the modification in writing but did not include a date when a final determination would be made as required by Labor Code section 4610(g)(5). This court found that completion of the evaluation 26 months later does not constitute a relatively expedited evaluation. Nonetheless, the court found that the URD was untimely because the URD did not issue within 5 working days of receipt of the report.

Once the evaluation was completed, Dr. Miller submitted another RFA for home health care services based upon his review of the report. SCIF indicates that the request was received on Tuesday, November 25, 2014. The URD denying the request for home health care services is dated December 9, 2014, seven business days later. The URD indicates that the decision was made on December 8, 2014, six business days later. There is no evidence that the decision was communicated to Dr. Miller by telephone, facsimile or electronic mail within 24 hours of decision being made. The URD is untimely giving the court jurisdiction to determine whether home health care services should be provided.

IS THE REQUESTING PHYSICIAN REQUIRED TO STATE THE TREATMENT GUIDELINE RELIED UPON FOR THE MEDICAL REPORT TO BE SUBSTANTIAL MEDICAL EVIDENCE?

SCIF contends that the requesting physician must specify the medical treatment guideline that supports the treatment requested for the medical report to be substantial medical evidence. While identification of the treatment guideline might expedite approval of the request, it is not a required component of a medical report or Request for Authorization. Section 10606 sets for the requirements for a medical report. Nowhere is there a requirement that the physician state the medical treatment guideline relied upon. Labor Code section 4600 requires that treatment be consistent with the guidelines adopted by the administrative director but it does not require the

physician state in his or her medical report the guideline relied upon in forming his or her opinion. The request for authorization is a state required form that requires the physician provide the diagnosis, the ICD-Code, and the service or goods requested. Other information can be provided but is not required. The RFA does not require the physician identify the treatment guideline relied upon. While the criteria or treatment guideline used in approving, modifying, delaying or denying a treatment request must be stated in the utilization review determination there is no similar requirement that the physician requesting treatment identify the treatment guideline or other criteria which supports the request. (*Lab. Code* §4610(g)(5). A request for medical treatment must only be supported by substantial medical evidence.

IS THE COURT REQUIRED TO FOLLOW THE MEDICARE BENEFITS MANUAL IN DETERMINING WHAT HOME HEALTH SHOULD BE PROVIDED?

SCIF denied home health care services because the Medicare Benefits Manual limits services to 28 hours per week and because the Medicare Benefits Manual provides that authorization should not be given if the services are being provided by a member of the patient's household. (Exhibit A, p. 4.) The Medicare Benefits Manual should not be used to determine the issue. Labor code section 4610.5 sets out a hierarchy of resources to be used in determining whether a particular modality is appropriate. The MTUS are at the top of that list. Contrary to SCIF's assertion, the Chronic Pain Medical Treatment Guidelines do address home health care services on page 51. Specifically they provide:

> Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed.

The guidelines adopted in 2009 were based primarily on the Official Disability Guidelines. Since these guidelines were adopted, the legislature has passed Senate Bill 863 which included Labor Code section 5307.8. The newly enacted legislation requires the administrative director to adopt a schedule for payment of home health care services not covered by Medicare or the official medical fee schedule. Furthermore, the schedule shall set forth the maximum service hours and fees in accordance with Article 7, commencing with section 12300, of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code. The Welfare and Institutions Code includes provision for personal care services such as bathing, dressing, and use of the bathroom. It also includes domestic services, heavy cleaning, and transportation. To the extent that Labor Code section 5307.8 is in conflict with the MTUS, the Labor Code will be followed. Taking into consideration the recommendation of the treating physician, the concurring recommendation of the RN after her on-site evaluation, and the provisions of Labor Code sections 4600, 4603.2 and 5307.8, this court found that home care services should be provided.

The Welfare and Institutions Code allows for payment of services up to 283 hours per month. Dr. Miller has repeatedly stated applicant needs assistance with activities of daily living seven days per week. The RN evaluation was consistent with Dr. Miller's opinion that applicant needs daily assistance with nutritional meal preparation, grocery shopping, grooming, hygiene, transfers into and out of the shower, bathing, dressing, transportation services and assistance transferring in and out of vehicle, home cleaning services, laundry tasks, assistance opening medication bottles and verbal reminders to take medications. Both Dr. Miller and RN Zamudio, estimated that the daily assistance would take 12 hours per day. However, as the applicant's activities vary day to day, the physician cannot with any degree of medical probability determine how much time will be needed on any given day. The physician can only state the maximum amount of time needed. Once there is

a prescription for services, the applicant must establish that the services requested were not received prior to the injury and the caregiver must provide an itemized statement of the services actually performed before payment will issue. (*Lab. Code* §§4603.2 and 5307.8.)

IS THE PRESCRIPTION REQUIRED TO SET FORTH WHAT SERVICES WERE PROVIDED PRIOR TO THE INJURY?

Labor Code section 5307.8 provides that:

> No fees shall be provided for any services, including any services provided by a member of the employee's household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of injury.

This provision is a payment issue not an entitlement issue. At the time of trial, applicant appeared but was unable to medically stay through the end of the day. As this is a payment issue, the court ordered that the record be developed. SCIF's request for reconsideration on this basis is premature and will not be further addressed.

CONCLUSION

The utilization review determination was untimely and therefore the court had jurisdiction to determine whether home health care services are reasonably required to cure or relieve the applicant from the effects of his industrial injury. The opinion of Lawrence R. Miller, M.D. is substantial medical evidence. While this court finds the petition for reconsideration to be without merit, the court recommends reconsideration for further study be granted on this recurring issue of importance to the workers' compensation community.

DATE: August 4, 2015

Anne J. Horelly
WORKERS' COMPENSATION
ADMINISTRATIVE LAW JUDGE