WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

EFREN LARA SOLANO

vs.

SHILOH RANCH and/or KATHLEEN DOWNS;
STATE COMPENSATION INSURANCE FUND, *Defendants*

Adjudication Number: ADJ14075660
Oxnard District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

Defendant seeks reconsideration of the Findings and Orders (F&O)[1] issued on April 16, 2024, wherein the workers' compensation administrative law judge (WCJ) found that (1) while employed as a laborer on November 18, 2020, applicant sustained injury arising out of and in the course of employment to his skull, face, brain, ribs, and right thumb; (2) there was no safe discharge plan in place when the request for authorization for further treatment from lien claimant Casa Colina was denied; (3) applicant was entitled to "concurrent" utilization review (UR) of requests for authorization of medical treatment due to his inpatient status under Labor Code section 4610(i), rendering defendant's UR untimely; (4) Labor Code section 4610(i)(4)(C) and Administrative Director's Rule 9792.9.1(e)(6) bar defendant from discontinuing applicant's inpatient care until it has obtained agreement from applicant's physician as to a safe discharge plan appropriate for his medical needs; (5) the record does not support defendant's petition for reimbursement; and (6) the parties are to bear their own costs.

The WCJ ordered that defendant's petition for reimbursement and lien claimant's motion for attorney's fees be denied.

Defendant contends that (1) its UR determinations were timely; (2) it is entitled to reimbursement for payments made for residential treatment provided to applicant because it disputed the medical necessity of the treatment and applicant did not seek Independent Medical Review (IMR) of its UR determinations denying treatment; and (3) it was not required by Labor

[1] Commissioner Sweeney, who served on the panel that issued the previous opinion and decision after reconsideration in this case, no longer serves on the Appeals Board. Commissioner Capurro has been substituted in her place.

Code Section 4610(i)(4)(C) to obtain agreement from applicant's physician as to a safe discharge plan before discontinuing treatment.

We have received an Answer from lien claimant.

The WCJ issued a Report and Recommendation on Petition for Reconsideration (Report) recommending that the Petition be denied.

Defendant and lien claimant filed papers labeled as supplemental pleadings.[2]

We have reviewed the Petition for Reconsideration, the Answer, and the contents of the Report. Based upon our review of the record and as discussed below, we will deny reconsideration.

FACTUAL BACKGROUND

On August 15, 2022, defendant filed a petition for reimbursement from lien claimant, alleging that "per Labor Code § 4610.5(e), State Fund has no liability for the cost of residential treatment at the TLC facility beyond the initial 14-day period." (Petition for Joinder/Reimbursement, August 15, 2022, p. 2:17-18.)

On March 8, 2024, the matter proceeded to trial of the following issues:

> 1. SCIF petitioned for reimbursement in the amount of $78,356.
> 2. Attorney's fees to Tappin & Associates for defending the Petition for Reimbursement.
> (Minutes of Hearing, March 8, 2024, p. 3:15-17.)

The WCJ admitted the May 15, 2021 Utilization Review Non-Certification into evidence. It states:

> **UR Determination**:
> Item 1. The prospective request for 1 continued Casa Colina Transitional Living Center Interdisciplinary Post-Acute residential rehabilitation program with 4-6

[2] We do not accept the parties' papers labeled as supplemental pleadings because they do not set forth good cause for approval or attach a proposed supplemental pleading as required by WCAB Rule 10964, which provides as follows:

(a) When a petition for reconsideration, removal or disqualification has been timely filed, supplemental petitions or pleadings or responses other than the answer shall be considered only when specifically requested or approved by the Appeals Board.

(b) A party seeking to file a supplemental pleading shall file a petition setting forth good cause for the Appeals Board to approve the filing of a supplemental pleading and shall attach the proposed pleading.

(c) Supplemental petitions or pleadings or responses other than the answer shall neither be accepted nor deemed filed for any purpose except as provided by this rule.

(Cal. Code Regs., tit. 8, § 10964.)

hours of therapy (Monday through Sunday from 5/3/2021-6/2/2021) is non certified.

. . .

Determination Rationale/Guidelines:

Item 1: The prospective request for 1 continued Casa Colina Transitional Living Center Interdisciplinary Post-Acute residential rehabilitation program with 4-6 hours of therapy (Monday through Sunday from 5/3/2021-6/2/2021) is non certified.

a. Rationale

i.

After review of the submitted documents and guidelines, it appears the prior non-certification was warranted. Available records do indicate continued cognitive deficits, however significant progress in both cognition and function has been made to date. The provider did indicate obstacles in the claimant's current living situation, but they do not justify the medical necessity of additional intensive care in a living facility. Transition to outpatient care seems relevant at this time, therefore the requested appeal for 1 continued Casa Colina Transitional Living Center Interdisciplinary Post-Acute residential rehabilitation program with 4-6 hours of therapy (Monday through Sunday from 5/3/2021-6/2/2021) is non-certified.

(Ex. C, May 15, 2021 Utilization Review Non-Certification, pp. 1, 3-4.)

The WCJ admitted the Request for Authorization dated September 30, 2021 into evidence. It shows that it was faxed to defendant at 3:52 p.m. on September 30, 2021, and that it requested "Home and Community Program - eval and treatment" and "Home Health Aide 8 hours per day 7 days per week for 3 months then re-eval." (Ex. 5, Request for Authorization dated September 30, 2021, p. 1.)

The WCJ admitted the Report of Allen Huang, M.D. dated September 30, 2021 into evidence. It shows that it was faxed to defendant at 3:53 p.m. on September 30, 2021, and states:

Patient is being discharged to home due to lack of authorization. Patient continues to suffer from cognitive deficits, impaired memory attention and concentration. The patient will require a home health aide due to safety concerns in the home and community. Patient will also require a continued post-acute rehabilitation in the form of a home and community program.

Impression:

1. Industrial related TBI with Polytrauma
2. Left Sided CN VII Palsy
3. Diffuse Subarachnoid Hemorrhage

4. Pneumocephalus
5. Post Traumatic Headaches with migrainous features
6. Right shoulder pain
7. TBI related cognitive impairments
8. Right thumb Bennett's fracture (Trapezium fracture) s/p CRPP
9. Right thumb hyperesthesia
10. Chronic Bilateral Spondylosis of LS with Grade I Spondylolisthesis at L5-S 1
11. Left low back pain
12. Left sided hearing loss worse than the right
13. Left jaw pain
14. Left 3-7th rib fractures (minimally displaced)
15. Right 4th anterlolateral fracture (non-displaced)
16. Double vision & Blurry vision
17. Possible left inferior visual field deficit
18. Horizontal Nystagmus on Leftward gaze
19. Right temporal calvarium and sphenoid wing fractures extend to the right superior lateral orbital wall and right lateral orbital wall.
20. Right-sided LeFort type Ill fracture.
21. Extraconal hematoma and soft tissue air within the right superior lateral orbit measuring 4 mm contrast asymmetric right globe proptosis.
22. Comminuted right zygomatic arch fracture
23. Nasal septal fracture (without nasal septal hematoma)
24. Dyspnea from left nostril secondary to nasal fracture
25. Insomnia
26. Depression/Anxiety/Adjustment Disorder/PTSD
27. Possible Pseudobulbar affect

(Ex. 15, Report of Allen Huang, M.D. dated September 30, 2021, pp. 1-2.)

The WCJ admitted the Genex UR dated October 9, 2021 into evidence. It states:

Documentation indicates the claimant suffers residual symptoms and impairments post TBI. The guidelines support the request for this reason as mentioned above. The request for treatment, however, cannot be justified without knowing what specific treatment recommendations are being requested and the rationale for those requests. Therefore the prospective request for 1 home and community program evaluation and treatment is certified with modification to evaluation only. Any treatment request is non-certified.

. . .

Documentation indicates the claimant suffers residual symptoms and impairments post TBI. The documented deficits do not confine the individual to the home or require skilled nursing care. The guidelines do not support the requests when the individual is not confined to the home, does not require skilled nursing care or more than 8 hours a day and over 28 hours a week. Therefore the prospective request for 3 months of home health aide for 8 hours per day, 7 days per week is non-certified.
(Ex. T, Genex UR dated October 9, 2021, p. 5.)

In the Report, the WCJ states:

"He (applicant) was working near the back of a truck, spraying water/chemicals on avocado trees. The brakes went out, the vehicle rolled over and he was trapped underneath. He lost and regained consciousness at the scene. He was taken by helicopter to Ventura County Medical Center. He was hospitalized for one week. He suffered a head trauma (skull fracture and brain hemorrhage), fractured facial bones and ribs, and a fracture of his right thumb." SCIF trial brief dated 12/17/2021, page 1-2.

SCIF seeks $78,356.00 in reimbursement from medical provider Casa Colina.

On 3/8/2024, at trial on SCIF's petition for reimbursement the parties stipulated that:

Applicant took part in the Short-Term Residential Program Post-Acute Rehab provided by Casa Colina. While participating in this program, he temporarily resided at a facility known as the Transitional Living Center (TLC) on Casa Colina's Pomona campus. He resided at the TLC facility from 4/19/2021 through 10/1/2021.

Casa Colina billed SCIF for this treatment. SCIF paid Casa Colina at the contracted rate of $1,031 per day, totaling $123,720 for 120 days.

The initial 14-day period of residential treatment ($14,434) was medically necessary and is excluded from the reimbursement claim for this reason.

An additional 30-day period ($30,930) is also excluded from the reimbursement claim based on an ad hoc compromise that the applicant and SCIF made at the expedited on 8/27/2021. The medical necessity of this 30-day period of residential treatment is disputed. See Minutes of Hearing dated 3/8/2024, page 2, line 21 to page 3, line 11.

The parties stipulated that during this period of residence, in addition to room and board, applicant received interdisciplinary rehab services (PT, OT, ST, and neuropsychology), medical management and nursing oversight at the TLC facility. See Minutes of Hearing dated 3/8/2024, page 3, lines 1-3.

. . .

It is a miracle applicant survived. That he survived is in large part to the medical treatment he received. In serious cases such as this the concept of a safe discharge plan is essential.

The undersigned found the record supported finding utilization review untimely, no change of condition or circumstance to justify discharge, and that there was no attempt at generating a safe discharge plan with Dr. Huang.
(Report, pp. 2-7, 11.)

DISCUSSION

We turn first to defendant's contention that its UR determinations were timely. Specifically, defendant argues that its decisions "were timely according to the 5/14 day timeframe" allowed for decisions concerning concurrent treatment. (Petition, p. 3:17-21.)

Labor Code section 4610(i) applies to RFAs for treatment, whether made "prior to, retrospectively, or concurrent with the provisions of medical treatment services." (Lab. Code § 4610(i).) Under Labor Code section 4610(i)(3), "If the employee's condition is one in which the employee faces an imminent and serious threat to the employee's health . . . , or the normal timeframe for the decisionmaking process . . . would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination." (Lab. Code § 4610(i)(3); see also Cal. Code Regs., tit. 8, § 9792.9.1(e)(3).)

Here, the record shows that applicant's condition involved an imminent and serious threat to his health, i.e., that he needed post-acute residential care to survive and recover from injuries including traumatic brain injury with cognitive impairment, vision and hearing deficits, and fractures to the ribs, knee, and skull with resultant depression and post traumatic injury syndrome. (Ex. 15, Report of Allen Huang, M.D. dated September 30, 2021, pp. 1-2.) However, defendant does not allege, and the record does not show, that any of the UR decisions were issued in a timely fashion appropriate to applicant's condition or within 72 hours of receipt of the information reasonably needed to make the determination. Consequently, we are unable to discern error in the WCJ's finding that the UR decisions were untimely.

Accordingly, we are persuaded that the WCJ was authorized to determine the issue of what medical treatment is reasonably required to cure or relieve applicant from the effects of his injury. (*Dubon v. World Restoration, Inc*. (2014) 79 Cal.Comp.Cases 1298 (Appeals Board en banc) (writ den.) (*Dubon II*); see also *Dubon v. World Restoration, Inc*. (2014) 79 Cal.Comp.Cases 313 (*Dubon I*); *Bodam v. San Bernardino County/Department of Soc. Servs.* (2014) 79 Cal.Comp.Cases 1519, 1521 (significant panel decision).)

Although we discern no error in the WCJ's finding that the UR determinations were untimely and, as such, that applicant's medical treatment was not subject to UR, we nevertheless address defendant's contention that the record establishes its entitlement to reimbursement for payments made for residential treatment provided to applicant after it disputed the medical necessity of the treatment. Specifically, defendant argues that after it issued UR determinations denying applicant's requests for continued residential treatment, applicant was required by Labor Code section 4610.5 to seek IMR of the determinations or be bound by them—and that applicant's failure to seek IMR gives rise to a right of reimbursement. (Petition, p. 6:3-7.)

Generally, Labor Code section 4610.5 makes IMR applicable to "any dispute over a utilization review decision," requires that any such dispute "be resolved only" by IMR, and precludes "liability for medical treatment furnished without the authorization of the employer if the treatment is modified or denied by a utilization review decision, unless the utilization review decision is overturned by [IMR]." (Lab. Code § 4610.5(a-b), (e).)

But "where the injured worker can demonstrate that the disputed utilization review determination is untimely or suffers from material procedural defects that undermine the integrity of the utilization review decision . . .' the issue of medical necessity is not subject to IMR but is to be determined by the Workers' Compensation Appeals Board based upon substantial evidence, with the employee having the burden of proving the treatment is reasonably required.'" *(Dubon I*).)

In this regard, assuming arguendo that the UR determinations were timely, defendant contends that because it did not authorize applicant's residential treatment beyond the first fourteen days, and because applicant requested that the treatment be continued by way of UR, the dispute over the medical necessity of applicant's residential treatment was governed exclusively by UR.

As to the argument that the residential treatment is governed by UR after expiration of fourteen days, we observe that in *Patterson v. The Oaks Farm* (2014) 79 Cal.Comp.Cases 910 (Appeals Board significant panel decision),[3] the Appeals Board held that an employer may not

[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 [75 Cal.Comp.Cases 81]; *Larch v. Workers' Comp. Appeals Bd*. (1999) 64 Cal.Comp.Cases 1098, 1099-1100 (writ den.); see also Cal. Code Regs., tit. 8, §§ 10305(r), 10325(b).)

unilaterally cease to provide treatment authorized as reasonably required to cure or relieve the effects of industrial injury upon an employee without substantial medical evidence of a change in the employee's circumstances or condition. The panel reasoned:

> Defendant acknowledged the reasonableness and necessity of [the medical treatment at issue] when it first authorized [that treatment], and applicant does not have the burden of proving [its] ongoing reasonableness and necessity. Rather, it is defendant's burden to show that the continued provision of the [treatment] is no longer reasonably required because of a change in applicant's condition or circumstances. Defendant cannot shift its burden onto applicant by requiring a new Request for Authorization [RFA] and starting the process over again.
> (*Patterson*, *supra*, at p. 918.)

In *Nat'l Cement Co., Inc. v Workers' Comp. Appeals Bd. (Rivota*) (2021) 86 Cal.Comp.Cases 595, the Second District Court of Appeal upheld the Appeals Board's application of *Patterson* to award an applicant continued inpatient care at Casa Colina, stating:

> [T]he principles advanced in [*Patterson*] apply to other medical treatment modalities as well. Here . . . Applicant had continued need for placement at Casa Colina. Further, [applicant's witness] stated that there was no change in Applicant's circumstance and no reasonable basis to discharge Applicant from care. The WCJ . . . concluded that Applicant's continued care at Casa Colina was necessary, without ongoing RFAs, to ensure Applicant's safety and provide him with a stable living situation and uninterrupted medical treatment.
> (*Rivota*, *supra*, at p. 597.)

In upholding this application of *Patterson*, the *Rivota* court rejected the employer's attempt to distinguish it on the grounds that it had never authorized inpatient care for an unlimited or ongoing period, never relinquished its right to conduct UR, and never been subject to a finding that inpatient treatment was reasonable and necessary for the applicant under section 4600. (*Id*.)

In this case, the record shows that defendant authorized fourteen days of residential treatment beginning on April 19, 2021, that applicant received an additional 30 days of residential treatment which defendant disputed until the issue was resolved by C&R, and that applicant's physician sought continued residential treatment by way of RFAs for the following days of residential treatment which were non-certified on the grounds that "[a]vailable records do indicate continued cognitive deficits" but not enough to "justify the medical necessity." (Report, pp. 2-7; Ex. C, May 15, 2021 Utilization Review Non-Certification, pp. 1, 3-4.)

Notably, the denials of RFAs for continued residential treatment do not suggest that defendant met its *Patterson* burden of proving that applicant experienced a change of

circumstances or condition warranting review and determination that the previously-authorized residential treatment was no longer medically necessary. Instead, the denials assert that applicant failed to meet his purported burden to "justify the medical necessity." (Ex. C, May 15, 2021 Utilization Review Non-Certification, pp. 1, 3-4.)

In the absence of evidence that defendant met its burden of proving a change in applicant's circumstances or condition warranting discontinuation of the residential treatment, *Patterson* applies to bar defendant's denials of RFAs for continued residential treatment from having any legal force or effect. Additionally, under *Rivota*, the mere fact that the original authorization for treatment was limited as to time does not justify the cessation of treatment without defendant establishing a change in applicant's circumstances or condition warranting the treatment's discontinuation. (See *Rivota*, *supra*, at p. 597.)

Since the record fails to show that defendant met its burden of demonstrating a change of circumstances or condition warranting denial of continued residential treatment, the issue of whether the residential treatment was no longer medically necessary was not governed by UR, even were the UR determinations timely, and applicant was not required to submit any of the adverse UR decisions to IMR in order to become entitled to continued residential treatment unless and until defendant met its burden of establishing a change in his circumstances or condition warranting discontinuation of treatment. (See *Dubon I*, *supra*, at p. 323 (stating that the right to have a UR decision reviewed through IMR is exclusively that of the employee and presupposes a valid UR determination. If a UR decision is invalid because its integrity was undermined there is no valid UR determination and no basis for the employee to invoke IMR); see also *Patterson*, *supra*.)

As to defendant's argument that the requests for continued residential treatment by way of UR make the dispute over the medical necessity of the treatment subject exclusively to UR, we are aware of no authority, and defendant cites none, suggesting that an injured worker who seeks UR thereby elects an exclusive remedy. To the contrary, our reading of the authorities is that (1) the WCAB may exercise jurisdiction over medical treatment requests for which UR determinations are untimely or suffer from material procedural defects that undermine the integrity of the UR decision irrespective of whether or not the applicant seeks an IMR; and (2) the applicant "may request an independent medical review" of UR decisions denying or modifying treatment requests irrespective of whether or not applicant challenges the UR decision as untimely or otherwise

invalid. *(Dubon I; Dubon II*; see also *Bodam v. San Bernardino County/Department of Soc. Servs.* (2014) 79 Cal.Comp.Cases 1519, 1521 (significant panel decision); Lab. Code § 4610.5(d).)

That applicant's requests for continued residential treatment were by way of UR thus has no bearing on the issue of whether the WCAB may exercise jurisdiction over the issue of whether the treatment was medically necessary. Accordingly, we discern no merit to defendant's argument that because it did not authorize applicant's residential treatment beyond the first fourteen days, and because applicant requested that the treatment be continued by way of UR, the dispute over the medical necessity of applicant's residential treatment was governed exclusively by UR.

Having discerned no error in the WCJ's (1) finding that defendant's UR determinations were untimely, (2) conclusion that defendant failed to establish a change of applicant's circumstances or condition warranting discontinuation of his residential treatment, or (3) rejection of defendant's argument that it was entitled to reimbursement based upon applicant's failure to seek IMR, we turn to defendant's foundational argument: that it is entitled to reimbursement pursuant to Labor Code section 4610.5(e) on the grounds that it paid for residential treatment not medically necessary. (Petition for Joinder/Reimbursement, August 15, 2022, p. 2:17-18.)

Here we observe that Labor Code section 4610.5(e) contains no statutory grant of authority for the relief requested; namely, reimbursement of payments made for applicant's treatment. Defendant appears to acknowledge as much in the Petition, arguing that it is entitled to restitution of lien claimant's allegedly "undeserved windfall"—a remedy that lies not in law, but equity. (Petition, p. 13:19.)

In order to recover restitution based upon general principles of equity, a party must establish unjust enrichment or some other basis for equitable relief. (*See American Psychometric Consultants v. Workers' Comp. Appeals Bd.* (*Hurtado*) (1995) 36 Cal. App. 4th 1626, 1645-46, 43 Cal. Rptr. 2d 254 [60 Cal.Comp.Cases 559, 573].) "[I]t is generally well settled that where a person with full knowledge of the facts voluntarily pays money under a mistake of law on a demand not legally enforceable against him, he cannot recover it in the absence of unjust enrichment, fraud, duress, or improper conduct of the payee." (*Id.* at 1646–47 (citing 66 Am.Jur.2d, § 138, p. 1070; accord, 55 Cal.Jur.3d, Restitution, § 10, p. 318.) In determining whether restitution is appropriate, "such factors as detrimental change of position, hardship, the implementation of some important public policy or transactional stability are considered." (*Hurtado*, *supra*, 36 Cal.App.4th at 1647, citing Dobbs, Law of Remedies (1973), § 11.9, pp. 767–772.)

Under certain circumstances it has been held that administrative tribunals such as the Appeals Board may appropriately employ equitable remedies. (*McHugh v. Santa Monica Rent Control Bd.* (1989) 49 Cal.3d 348, 355–356 [261 Cal. Rptr. 318, 777 P.2d 91].) Such use by the Board would seem particularly justified, for example, when fraud has been charged and proven. (Ins. Code, § 1871.4, subd. (b)[Deering's] and see, e.g., *House v. Workers' Comp. Appeals Bd*. (1993) 58 Cal.Comp.Cases 354.)

In the absence of pleadings and an evidentiary record establishing that defendant made payments to lien claimant as a result of fraud, however, we are aware of no basis in equity that would permit the Appeals Board to order restitution based merely on a claim that defendant made payments for treatment determined by UR/IMR to be not medically necessary. (*Weiner v. Ralphs Co*. (2009) 74 Cal.Comp.Cases 736, 753 [2009 Cal. Wrk. Comp. LEXIS 143] ["[t]he WCAB is a judicial body of limited jurisdiction, with no powers beyond those conferred on it by the Constitution and the Labor Code"].)

Accordingly, we discern no legal basis for defendant's claim in the first instance that it is entitled to reimbursement for payments made for residential treatment provided to applicant on the grounds that it disputed the medical necessity of the treatment and applicant did not seek IMR of its UR determinations denying treatment.

We next address defendant's contention that it was not required by Labor Code section 4610(i)(4)(C) to obtain agreement from applicant's physician for a safe discharge plan before discontinuing treatment.

Specifically, defendant argues that because applicant did not seek IMR following its UR determination denying applicant's RFA for in-home treatment and a home health aide and approving an evaluation of applicant's in-home treatment needs, defendant was not required to obtain applicant's physician's agreement for a care plan.

Labor Code section 4610(i)(4)(C), as applicable here, provides:

> In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve.

AD Rule 9792.9.1(e)(6) implementing Section 4610(i)(4)(C), provides:

> The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment:
>
> (A) Medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee.
>
> (B) Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

As we explained, defendant's UR determinations denying continued residential treatment were untimely and materially defective, rendering them incomplete and ineffective. Lien claimant, in the absence of a legal finding that the determinations were invalid, continued to provide applicant with residential treatment until September 30, 2021, when it requested that the treatment be discontinued in favor of home and community program treatment and home health care on the grounds that continued residential treatment had not been authorized. (Ex. 5, Request for Authorization dated September 30, 2021, p. 1; Ex. 15, Report of Allen Huang, M.D. dated September 30, 2021, pp. 1-2.) Since applicant sought continued residential treatment, and then sought home and community program treatment and home health care as a substitute for continued residential treatment based upon defendant's invalid denials of continued residential treatment, defendant was prohibited from discontinuing applicant's treatment without agreement from applicant's physician on a safe discharge plan. (Labor Code section 4610(i)(4)(C); see *Greenhall v. CalTech*, 2020 Cal. Wrk. Comp. P.D. LEXIS 269 (Cal. Workers' Comp. App. Bd. September 1, 2020).)[4] Contrary to this prohibition, however, defendant denied the home and community program treatment and home health care, placing applicant in a position to be discharged home without access to treatment of any kind. (Ex. T, Genex UR dated October 9, 2021, p. 5.)

Hence we conclude that the WCJ correctly found that Labor Code section 4610(i)(4)(C) and AD Rule 9792.9.1(e)(6) bar defendant from discontinuing applicant's residential treatment until it has obtained agreement from applicant's physician for a safe discharge plan appropriate for his medical needs.

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[4] WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and workers' compensation judges. (See *Gee v. Workers' Comp. Appeals Bd*. (2002) 96 Cal.App.4th 1418, 1425 fn. 6, 67 Cal.Comp.Cases 236]. While WCAB panel decisions are not binding, the WCAB may consider these decisions to the extent that it finds their reasoning persuasive. (See *Guitron v. Santa Fe Extruders* (2011) 76 Cal.Comp.Cases 228, fn. 7 (Appeals Board En Banc Opinion).)

Accordingly, we deny reconsideration.

For the foregoing reasons,

IT IS ORDERED that the Petition for Reconsideration of the Findings and Orders issued on April 16, 2024 is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSEPH V. CAPURRO, COMMISSIONER

I CONCUR,

/s/ JOSÉ H. RAZO, COMMISSIONER

ANNE SCHMITZ, DEPUTY COMMISSIONER
CONCURRING NOT SIGNING

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

JULY 12, 2024

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

EFREN LARA SOLANO
LAW OFFICES OF TAPPIN & ASSOCIATES
STATE COMPENSATION INSURANCE FUND

SRO/*cs*

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