WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

CARLOS CARTAGENA, *Applicant*

vs.

ORION ORNAMENTAL IRON, INC.; CYPRESS INSURANCE COMPANY, dba BERKSHIRE HATHAWAY HOMESTATE COMPANIES, *Defendants*

Adjudication Number: ADJ13656596
Oxnard District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

We have considered the allegations of the Petition for Reconsideration and the contents of the report of the workers' compensation administrative law judge (WCJ) with respect thereto. Based on our review of the record, and for the reasons stated in the WCJ's report, which we adopt and incorporate, we will deny reconsideration.

I.

Former Labor Code section 5909 provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.) Effective July 2, 2024, Labor Code section 5909 was amended to state in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.
>
> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

Under Labor Code section 5909(a), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected in Events in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on January 3, 2025, and 60 days from the date of transmission is Tuesday, March 4, 2025. This decision is issued by or on Tuesday, March 4, 2025, so that we have timely acted on the petition as required by Labor Code section 5909(a).

Labor Code section 5909(b)(1) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to act on a petition. Labor Code section 5909(b)(2) provides that service of the Report and Recommendation shall be notice of transmission.

Here, according to the proof of service for the Report and Recommendation by the workers' compensation administrative law judge, the Report was served on January 3, 2025, and the case was transmitted to the Appeals Board on January 3, 2025. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that the parties were provided with the notice of transmission required by Labor Code section 5909(b)(1) because service of the Report in compliance with Labor Code section 5909(b)(2) provided them with actual notice as to the commencement of the 60-day period on January 3, 2025.

II.

AD Rule 9792.9 (Cal. Code Regs., tit. 8, § 9792.9) states in relevant part that:

> (b) Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.
>
> > (1) If the claims administrator disputes its liability for the requested medical treatment under this subdivision, it may, no later than five (5) business days from receipt of the request for authorization, issue a written decision deferring utilization review of the requested treatment, unless the requesting

physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. ***The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.*** The written decision shall only contain the following information specific to the request:

> (A) The date on which the request for authorization was first received.
>
> (B) A description of the specific course of proposed medical treatment for which authorization was requested.
>
> (C) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
>
> (D) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
>
> (E) The following mandatory language advising the injured employee:
> "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."
>
> and
>
> "For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

(Cal. Code Regs., tit. 8, § 9792.9, emphasis added.)

Here, the deferral notice by defendant of November 18, 2020 (Exhibit J1) only shows service on the requesting physician; defendant produced no evidence that the notice was served on applicant and his attorney. Thus, defendant did not meet its burden to show that it complied with AD Rule 9792.9 to defer utilization review (UR), and defendant is not entitled to retroactive UR.

Accordingly, we deny the Petition for Reconsideration.

For the foregoing reasons,

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

WORKERS' COMPENSATION APPEALS BOARD

/s/ CRAIG SNELLINGS, COMMISSIONER

I CONCUR,

/s/ KATHERINE A. ZALEWSKI, CHAIR

/s/ LISA A. SUSSMAN, DEPUTY COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

March 4, 2025

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

CARLOS CARTAGENA
LAW OFFICE OF SAAM AHMADINIA
PEATMAN LAW GROUP

AS/oo

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

REPORT AND RECOMMENDATION
ON PETITION FOR RECONSIDERATION AND
NOTICE OF TRANSMITTAL TO THE
WORKERS COMPENSATION APPEALS BOARD

I
INTRODUCTION

Defendant, CYPRESS INSURANCE COMPANY c/o BERKSHIRE HATHAWAY HOMESTATE COMPANIES, by and through their attorneys of record, has filed a timely Petition for Reconsideration challenging the Findings and Order of 26 November 2024. In it Petitioner argues that the undersigned erred in finding in favor of lien claimant the DENTAL TRAUMA CENTER. Specifically, they argue that the undersigned erred in not enforcing the twelve-month statute of limitations during which liens claimants are generally required to issue billing for services within twelve months of services. They also argue that the undersigned erred in finding the evidence of the teeth being injured to be credible and timely. The also state that the if the lien claimant is shown to have prevailed on these two points, the undersigned should have permitted the defendant to send the Requests for Authorization (RFA) to utilization review (UR) by way of retro – UR.

To date, no answer to the Petition has been received.

This Report & Recommendation and Notice of Transmittal is sent to the Appeals Board on the date noted at the end of this document.

It is recommended that reconsideration be denied.

II
FACTS

Applicant, CARLOS CARTAGENA, aged 60 on the date of injury of 06 August 2020 while employed by ORION ORNAMENTAL IRON, INC., insured by CYPRESS INSURANCE COMPANY administered by the BERKSHIRE HATHAWAY HOMESTATE COMPANIES, sustained injury arising out of and in the course of employment to his lips and claims to have sustained injury arising out of and in the course of employment to his mouth, teeth, gums and face.

Mr. CARTAGENA was working as a welder for his employer in North Hollywood, California. On 06 August 2020, he was moving metal bars out of a truck with a co-worker when the co-worker caused one of the metal bars to strike the left side of applicant's face over his lip.

The injury was admitted on 03 November 2020 (Exhibit C) and defendant chose Dr. Gary J. Abdo, a doctor of osteopathy, as applicant's treating physician in the Medical Provider Network (MPN) in a letter to that doctor dated 21 October 2020 (See Exhibit E.)

On 28 October 2020, Dr. Abdo sent an RFA on the proper form requesting a referral to a dentist. (See Exhibit 8.) This RFA is supported by a report from Dr. Abdo that records that the applicant has moderate dull pain in the central lower teeth and has a loose tooth in the same area. (See Exhibit 9 at p. 1.) Defendant did not submit this RFA to UR but instead issued a letter dated 18 November 2020 denying the treatment. This letter acknowledged the RFA but indicated that UR may be deferred "on grounds other than medical necessity" and justified this position with a checkbox next to which read, "[t]he submitted request is for treatment of a disputed non-compensable body part." (See Joint Exhibit J-1.)

Applicant then sought dental treatment on his own and his attorney served a 4600-letter dated 19 November 2020 appointing Dr. Schames as applicant's primary treating physician. (See Exhibit 6.) Dr. Schames issued an initial report on 25 February 2021 which also requested authorization for dental treatment. (See Exhibits 4 and 5.)

The claims administrator then sent two letters: The first one seems to have denied the claim as of 16 February 2021 and the second one dated 06 March 2023 denies the treatment based on denial of this claim. There do not appear to be any medical reports among the exhibits which support the denial.

At trial, defendant submitted no medical reports that supported the denial of treatment or denial of the claim. However, at trial defendant did include some professional articles that defendant argues support the contention that the treatment was not appropriate. Defendant did not, however, provide any dental or medical reports that incorporated these documents in a medical – legal report. (See Exhibits G, H & J.) Defendant did not engage the services of any medical-legal provider to explain how these professional articles are relevant to the factual issues of this case.

The undersigned found in favor of the lien claimant.

III
DISCUSSION

Defendant, CYPRESS INSURANCE COMPANY makes three arguments in their Petition for Reconsideration: First, they argue that the lien claimant failed to timely submit the billing for their services to the employer as required by Labor Code § 4603.2 (b) (1.) This argument is

erroneous for two reasons. First and foremost, the lien claimant here did indeed serve its billing within 12 months of the date of service. However, they served co- defendant SECURITY NATIONAL INSURANCE COMPANY, not CYPRESS INSURANCE COMPANY.

The second reason is that while the Labor Code section in question does indeed provide that the billing should be served within 12 months of the services provided or when the patient is released from care, it also provides for exceptions to this limitations period. Specifically, it provides that the Administrative Director is required to make rules to implement that period of limitations. Also, the statute also provides that these rules, "shall define circumstances that constitute good cause for an exception to the 12-month period, including provisions to address the circumstances of a non-occupational injury or illness later found to be a compensable injury or illness."

Unfortunately, it appears that the Administrative Director never adopted the rules required under Labor Code § 4603.2 (b) (1.) Thus, despite the clear legislative intent to allow an exception to this limitations period, no regulations appear to have been adopted. Be that as it may, it is clear that the Legislature intends that this 12-month limitations period would not apply where the claim is initially denied as being non-industrial but becomes industrial later. It falls on the trial judge and the Appeals Board to implement this clear legislative mandate where the required regulation is absent.

Here, the defendant has consistently denied the dental portion of this claim until it was informed of the error of this position on 26 November 2024 when the Findings and Order found that the unrebutted credible medical evidence established a dental injury. Since the bill had long since been served as of November 2024, the issue of the 12-month limitations period is a moot point.

Defendant's second argument on Reconsideration is that the evidence is insufficient to support the decision. Specifically, defendant argues that there is insufficient evidence to support the conclusion that applicant was entitled to the orthotic devices provided. However, the undersigned merely followed the burden of proof. Defendant initially denied the treatment was payable based on a parts of body defense. On this basis they chose to short-circuit the UR procedures and to simply deny the treatment based on the assertion that the parts of body were not industrial.

The problem with this approach is that they left themselves without a defense based on medical opinion. The purpose of UR is to require the doctors to make the decisions on "reasonableness and necessity" under Labor Code § 4600 instead of adjusters, lawyers and judges. By having an adjuster make a decision instead of a doctor, they are now in a position where the only medical opinions in the case, those of Dr. Abdo and Dr. Schames, both support the need for the dental treatment. These opinions are credible expert opinion and un-rebutted.

Defendant does bring some professional articles to bear to support their position that some of the treatment may arguably be unnecessary. However, professional articles are for the use of those in those professions, not laypersons. An opinion of a lay adjuster in a denial does not overcome a medical opinion. The lack of a dental opinion to compare these articles to the facts of this case leaves defendant's position entirely unsupported.

Defendant's final argument is that it should be allowed to conduct retrospective review under Rule 9792.9 now that the part of body is found compensable. However, this assumes that the denial is made in good faith. The applicant in this case was struck in the mouth by an iron bar with sufficient force that he sought medical attention. The medical provider, a D.O. chosen by the carrier, determined that this caused the applicant to have loose teeth. The D.O. requested authorization for a dental consult. This was denied because the adjuster chose to deny the teeth on a part of body basis. However, at no time did the adjuster investigate the injury to the teeth by authorizing a consultation within the MPN or object and request a Panel QME or agree to an AME. There was no medical investigation of the part of body issue at all. The adjuster chose to deny the additional part of body without investigating at all. Such behavior should not be encouraged by giving the carrier a second chance to deny the treatment. They chose to deny the dental aspect of injury without investigation and they should be required to live with that choice. This result would be distinguishable from the situation where the adjuster chose to authorize a consult within the MPN where a report may have issued to support the adjuster's position.

If they had done so then upon reversal they would be in a position to obtain retrospective UR after an adverse finding by an AME or PQME.

IV
RECOMMENDATION

It is recommended that the Petition for Reconsideration be denied.

Respectfully submitted,

ROGER A. TOLMAN, JR.
Workers' Compensation Judge