WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

RICHARD ALFREDO MARAVILLA, *Applicant*

vs.

POOL TIME POOL SERVICE, INC.,
INSURANCE COMPANY OF THE WEST, *Defendants*

Adjudication Number: ADJ19183500
Sacramento District Office

OPINION AND ORDER GRANTING PETITION FOR RECONSIDERATION AND DECISION AFTER RECONSIDERATION

Lien claimant Spectrum Medical Group (lien claimant) seeks reconsideration of the March 11, 2025 Findings and Order (F&O), wherein the workers' compensation administrative law judge (WCJ) found that applicant while employed during the period of September 1, 2023 through April 15, 2024 by defendant as a swimming pool servicer did not sustain injury arising out of and in the course of employment to multiple body parts; that there is no liability for self-procured medical treatment; and that the lien of Spectrum Medical is denied.

Lien claimant contends that pursuant to Labor Code section[1] 4600, applicant and applicant's attorney properly designated Amin Nia, D.C., as the primary treating physician and requested and obtained a comprehensive medical-legal report under section 4060. Lien claimant contends that it is entitled to recovery of its lien pursuant to sections 4620 and 4060.

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

Lien claimant also filed a request to file supplemental pleading and a proposed "Answer to the WCJ Opinion and Recommendation on Lien Claimant's Petition for Reconsideration." We

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

have read and considered both pleadings pursuant to WCAB Rule 10964(a) and (b). (Cal. Code Regs., tit. 8, § 10964(a)-(b).)

We have considered the Petition, the Answer, the contents of the Report and the supplemental pleading. Based on our review of the record, and for the reasons discussed below, we will grant reconsideration, rescind the F&O and substitute new findings that Dr. Nia was a properly designated primary treating physician; that the medical-legal reporting was properly requested under section 4060; that lien claimant met their burden under section 4620; that lien claimant met their burden under section 4621; and that the issue of the amount of defendant's liability under section 4622 is deferred. We will return this matter to the WCJ for further proceedings consistent with this opinion.

BACKGROUND

We will briefly review the relevant facts.

Applicant claimed a cumulative injury to his neck, back, both shoulders, upper extremities, and right wrist/hand while employed by defendant as a swimming pool servicer, during the period from September 1, 2023 to April 15, 2024.

On April 26, 2024, applicant filed an Application for Adjudication (Application) for a cumulative injury from September 1, 2023, to April 15, 2024, to neck, back, both shoulders, upper extremities, wrist, and back. The case was assigned Case No. ADJ19183500.

On June 5, 2024, defendant denied applicant's claim for a cumulative injury in its entirety,

> "Your work-related cumulative trauma claim is denied because our investigation reveals no medical, legal or factual evidence to support a CT injury within ICW's period of insurance coverage. All issues are being handled on the Specific injury claim 202401044." (Exhibit 101, June 5, 2024.)

On June 18, 2024, applicant and his attorney designated Dr. Nia with Spectrum Medical Group, Inc., as applicant's primary treating physician (PTP) for treatment and evaluation. (Exhibit 1, June 18, 2024.) The letter requests that Dr. Nia perform a medical-legal evaluation because defendant denied applicant's cumulative injury claim. (Exhibit 1, June 18, 2024.)

On June 19, 2024, Dr. Nia examined applicant and issued a Primary Treating Physician's Comprehensive Medical-Legal AOE/COE Report for applicant's claimed injury of September 1, 2023, through April 15, 2024. (Exhibit 8, June 19, 2024.) The report is addressed to the applicant's attorney and defendant. The report begins by saying that:

This Medical-Legal report is issued pursuant to Labor Code §§4620, *et seq.* and 5307.6, and California Code of Regulations § 9793(c)(2), which defines a comprehensive medical-legal evaluation as an evaluation of an injured worker which results in the preparation of a narrative medical report, and is performed by **the primary treating physician** for the purpose of proving or disproving a **contested claim**; **and** California Code of Regulations § 9793(h)(2), which provides **that the report is obtained at the request of a party or parties** for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party who requested the comprehensive medical-legal evaluation report.

This **patient alleges injuries to body parts which are in dispute.** I have conducted a Medical- Legal evaluation to determine if the injuries to these body parts occurred as a consequence of the industrial injuries referenced above.

Pursuant to California Code of Regulations §9793(b)(1), a contested claim is one in which the claims administrator has rejected liability for a claimed benefit. (Emphasis in the original)

(Exhibit 8, June 19, 2024.)

After evaluating applicant, Dr. Nia concluded,

"The determination of whether an injury arose out of employment is a medical decision based on a plausible mechanism of injury that aligns with clinical and diagnostic findings. The responsibility to present substantive information to support a case for industrial causation rests with the applicant. Regarding continuous trauma claims, it is sufficient that the work activities contributed at least in part to the injury; the threshold for industrial causation of musculoskeletal injuries is 1%, according to the workers' compensation laws in California.

The applicant is claiming continuous trauma to the cervical spine, thoracic spine, lumbar spine, bilateral shoulders, bilateral elbows, bilateral wrists, and bilateral hands as a result of performing the usual and customary job duties of a Maintenance Worker for Pool Time Pole Service, Inc. from 09/01/2023 to 04/15/2024. The job duties were reportedly arduous and included heavy lifting, repeated gripping, grasping, hand movements, twisting, bending, kneeling, squatting, stooping, and prolonged periods of sitting, walking, standing, lifting, and carrying, which support a continuous trauma mechanism of injury to the cervical spine, thoracic spine, bilateral shoulders, bilateral elbows, bilateral wrists, and bilateral hands.

Objective findings and diagnostic studies are consistent with the reported industrial injury and underlying arthropathy, which will be addressed as an apportionment once he reaches Maximum Medical Improvement (MMI)."

(Exhibit 8, June 19, 2024.)

On June 28, 2024, the parties entered into a C&R resolving their dispute. (Exhibit D, June 28, 2024.) In Paragraph 9, it is noted that "CT claim denied AOE/COE." On July 2, 2024, a WCJ issued an OACR. (Exhibit E, July 2, 2024.)

On July 8, 2024, lien claimant filed notice and request for allowance of lien.

On February 25, 2025, lien claimant and defendant proceeded to trial. Among the issues were injury AOE/COE; liability for self-procured medical treatment; lien of Spectrum Medical; and whether applicant is entitled to request a medical-legal evaluation performed by their designated PTP to address a disputed medical issue.

On March 11, 2025, the WCJ issued his decision, determining in relevant part that "The injury is not AOE/COE for all parts of the body alleged. There is no liability for self-procured medical treatment. The Lien of Spectrum Medical, in the amount of $ 3,351.44 is hereby denied."

DISCUSSION

I.

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

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

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

Here, according to Events, the case was transmitted to the Appeals Board on April 14, 2025, and 60 days from the date of transmission is June 13, 2025. This decision is issued by or on June 13, 2025, so that we have timely acted on the petition as required by section 5909(a).

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

Here, according to the proof of service for the Report and Recommendation by the workers' compensation administrative law judge, the Report was served on April 14, 2025, and the case was transmitted to the Appeals Board on April 14, 2025. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that the parties were provided with the notice of transmission required by section 5909(b)(1) because service of the Report in compliance with section 5909(b)(2) provided them with actual notice as to the commencement of the 60-day period on April 14, 2025.

II.

Section 4060(b) allows a medical-legal evaluation by the treating physician. Section 4620(a) defines medical-legal expense as "any costs and expenses…for the purpose of proving or disproving a contested claim." Section 4064(a) provides that the employer is liable for the cost of a comprehensive medical evaluation that is authorized by section 4060.

The regulations provide that the "primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation..." (Cal. Code Regs., tit. 8, § 9785(d).)

AD Rule 9793(h) states:

> (h) "Medical-legal expense" means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim. The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-legal evaluation report, follow-up medical-legal evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist:

(1) The report is prepared by a physician, as defined in Section 3209.3 of the Labor Code.

(2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues.

(3) The report is capable of proving or disproving a disputed medical fact essential to the resolution of a contested claim, considering the substance as well as the form of the report, as required by applicable statutes, regulations, and case law.

(4) The medical-legal examination is performed prior to receipt of notice by the physician, the employee, or the employee's attorney, that the disputed medical fact or facts for which the report was requested have been resolved.

(5) In the event the comprehensive medical-legal evaluation is served on the claims administrator after the disputed medical fact or facts for which the report was requested have been resolved, the report is served within the time frame specified in Section 139.2(j)(1) of the Labor Code.

(Cal. Code Regs., tit. 8, § 9793(h).)

Read together, these sections provide that a medical-legal evaluation performed by an employee's treating physician is a medical-legal evaluation obtained pursuant to section 4060 and that an employer is liable for the cost of reasonable and necessary medical-legal reports that are performed by the treating physician. The Appeals Board has previously held that there was no legal authority to support the proposition that an injured worker is not entitled to request a medical-legal report from their PTP, and in turn, the report from that PTP is a medical-legal expense for which the defendant is liable. (*Warren Brower v. David Jones Construction* (2014) 79 Cal.Comp.Cases 550, 556 (Appeals Board en banc).) Moreover, a medical-legal expense is ordinarily allowable if it is capable of proving or disproving a contested claim, if the expense was reasonably necessary at the time incurred, and if the cost incurred was reasonable. (Lab. Code, §§ 4620 et seq., 5307.6.)

The Labor Code sections discussed above do not include the limitations set forth in AD Rule 9793(h). It is clear that the intent of section 4060(b) when read together with section 4064(a) is that a medical-legal evaluation performed by an employee's treating physician is a medical-legal

evaluation obtained pursuant to section 4060 and that an employer is liable for the cost of reasonable and necessary medical-legal reports that are performed by the treating physician.

Section 4061.5 states that:

> the treating physician primarily responsible for managing the care of the injured worker or the physician designated by that treating physician shall, in accordance with rules promulgated by the administrative director, render opinions on all medical issues necessary to determine eligibility for compensation.

(Lab. Code, § 4061.5.)

Here, we note that on June 18, 2024, applicant's attorney issued a letter to Dr. Nia stating that applicant is electing Dr. Nia as his treating physician for evaluation and treatment. Applicant was seen by Dr. Nia for his cumulative injury because defendant denied his cumulative injury claim, and additionally, the letter requested a medical-legal report.

Here, the issue is whether the June 19, 2024, report is a medical-legal report for which medical-legal expenses may be recovered by lien claimant. The WCJ concluded that it was not a medical-legal report because there was no Doctor's First Report. We disagree. The lack of a Doctor's First Report does not invalidate the designation or request that Dr. Nia serve as the PTP, and we conclude that Dr. Nia's Report is a medical-legal report and that the expenses should be recovered by lien claimant.

A lien claimant holds the burden of proof to establish all elements necessary to establish its entitlement to payment for a medical-legal expense. (See Lab. Code, §§ 3205.5, 5705; *Torres v. AJC Sandblasting* (2012) 77 Cal.Comp.Cases 1113, 1115 [2012 Cal. Wrk. Comp. LEXIS 160] (Appeals Board en banc).) Thus, a lien claimant is required to establish that: 1) a contested claim existed at the time the expenses were incurred; 2) the expenses were incurred for the purpose of proving or disproving the contested claim; and 3) the expenses were reasonable and necessary at the time they were incurred. (Lab. Code, §§ 4620, 4621, 4622(f); *American Psychometric Consultants Inc. v. Workers' Comp. Appeals Bd.* (*Hurtado*) (1995) 36 Cal.App.4th 1626 [60 Cal.Comp.Cases 559].) Pursuant to *Colamonico v. Secure Transportation* (2019) 84 Cal.Comp.Cases 1059 (Appeals Board en banc), a lien claimant holds the initial burden of proof under sections 4620 and 4621, and once a lien claimant has established these elements, they then may proceed to address the reasonable value of the services under section 4622.

Lien claimant's initial burden in proving entitlement to reimbursement for a medical-legal expense is to show that a "contested claim" existed at the time the service was performed. Subsection (b) sets forth the parameters for determining whether a contested claim existed (Lab. Code, § 4620(b).) There is a contested claim when: 1) the employer knows or reasonably should know of an employee's claim for workers' compensation benefits; and 2) the employer denies the employee's claim outright or fails to act within a reasonable time regarding the claim. (Lab. Code, § 4620(b).)

Here, on April 26, 2024, applicant filed an Application claiming a cumulative injury from September 1, 2023, to April 15, 2024. On June 5, 2024, defendant denied liability for applicant's claimed injury of September 1, 2023, to April 15, 2024. On June 19, 2024, PTP Dr. Nia, examined applicant and issued a medical-legal report for the purpose of proving applicant's cumulative injury claim on June 25, 2024. Thereafter, on June 28, 2024, the parties entered into a C&R, which stated that "CT claim denied AOE/COE," and the form language of the C&R states that: "There is a serious and legitimate dispute regarding AOE/COE." Based on the record before us, we believe that lien claimant met their burden to show that the claim is a "contested claim." Moreover, since applicant's cumulative injury claim was denied, it was reasonable and necessary for applicant to seek medical-legal reporting as evidence in support of his claim of injury. As explained above, once lien claimant has met the burden of proof pursuant to sections 4620 and 4621, then the analysis shifts to the reasonable value of the services pursuant to section 4622.

Accordingly, we grant lien claimant's Petition for Reconsideration, rescind the F&O, and substitute a new F&O that finds that Dr. Nia was a properly designated PTP; that the medical-legal reporting was properly requested under section 4060; that lien claimant met their burden under section 4620; that lien claimant met their burden under section 4621; and that the issue of the amount of defendant's liability under section 4622 is deferred. We return this matter to the WCJ for further proceedings consistent with this opinion.

For the foregoing reasons,

IT IS ORDERED that lien claimant's Petition for Reconsideration of the March 11, 2025 Findings and Order is **GRANTED**.

IT IS FURTHER ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the March 11, 2025 Findings and Order is **RESCINDED** and **SUBSTITUTED** with a new Findings and Order as Provided below and the matter is **RETURNED** to the trial level for further proceedings by the WCJ consistent with this opinion.

FINDINGS OF FACT

1. Lien claimant, Dr. Nia with Spectrum Medical Group was properly designated as applicant's primary treating physician.

2. The medical-legal report issued by Dr. Nia on June 19, 2024 was properly requested pursuant to Labor Code section 4060.

3. Lien claimant met their burden to show that a contested claim existed pursuant to Labor Code section 4620 and that the medical-legal reporting was requested to prove a disputed claim.

4. Lien claimant met their burden to show that the medical-legal reporting was reasonably and necessarily obtained pursuant to Labor Code section 4621.

5. The issue of the amount of defendant's liability under Labor Code section 4622, and for interest, costs, and penalties is deferred.

6. All other issues are deferred.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSEPH V. CAPURRO, COMMISSIONER

I CONCUR,

/s/ LISA A. SUSSMAN, DEPUTY COMMISSIONER

/s/ KATHERINE A. ZALEWSKI, CHAIR

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

June 13, 2025

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

SPECTRUM MEDICAL GROUP
INSURANCE COMPANY OF THE WEST

DLM/oo

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