

ASSEMBLY BILL

No. 1

Introduced by Assembly Member Maldonado

(Coauthors: Assembly Members Aghazarian, Bates, Benoit, Bogh, Campbell, Cogdill, Daucher, Garcia, Harman, Haynes, Shirley Horton, Houston, Keene, La Malfa, Leslie, Maddox, Maze, McCarthy, Nakanishi, Pacheco, Plescia, Richman, Runner, Samuelian, Spitzer, and Wyland)

November 18, 2003

An act to amend Section 1877.5 of the Insurance Code, and to amend Sections 3201.5, 3208, 3208.1, 3209.3, 3600, 4060, 4061, 4062, 4062.5, 4064, 4068, 4600, 4600.2, 4600.7, 4603.2, 4604, 4658, 4660, and 6401.7 of, to amend and renumber the heading of Part 1 (commencing with Section 3200) of Division 4 of, to add Sections 4600.31, 4604.5, 4611, 4611.1, 4611.2, 4658.1, 4658.6, and 5705.1 to, to add Article 2.3 (commencing with Section 3737) to Chapter 4 of Part 1.5 of Division 4 of, to add Part 1 (commencing with Section 3110) to Division 4 of, to repeal Sections 3139.48, 3139.49, 4062.9, 4600.35, 4600.6, 4601, 4602, 4603, 4609, 4614, 4614.1, and 5814.5 of, to repeal Chapter 5 (commencing with Section 110) of Division 1 of, and to repeal and add Sections 4600.3, 4600.5, and 5814 of, the Labor Code, relating to workers' compensation, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1, as introduced, Maldonado. Workers' compensation.

(1) Existing law establishes a workers' compensation system to compensate an employee for injuries sustained in the course of his or her employment. Chapters 635 and 639 of the Statutes of 2003 (AB 227

and SB 228) will make changes to the workers' compensation system effective January 1, 2004.

Existing law provides that the Division of Workers' Compensation is under the control of the administrative director.

This bill would repeal and renumber various provisions pertaining to the division. The bill would recast certain of these provisions relating to the procedures to be followed by physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury.

(2) Existing law establishes the Industrial Medical Council, consisting of various types of medical practitioners, and requires the council to perform various functions and duties in connection with the provision of medical services under the workers' compensation program. Existing law establishes the Industrial Medicine Fund into which specified fees are deposited for the administration of the council. Chapter 639 of the Statutes of 2003 will eliminate the council and transfer many of its functions and duties to the administrative director.

This bill would transfer additional functions and duties from the council to the administrative director. This bill would eliminate the Industrial Medicine Fund and require that the specified fees be deposited, instead, into the Workers' Compensation Administration Revolving Fund, available for expenditure upon appropriation by the Legislature, for the administration of the programs of the division related to the provision of medical treatment to injured employees. The bill would make conforming changes.

(3) Existing law authorizes collective bargaining agreements between a private employer or groups of employers and a recognized or certified exclusive bargaining representative that establish a dispute resolution process for workers' compensation instead of the hearing before the Workers' Compensation Appeals Board and its workers' compensation administrative law judges, or that provides for specified other alternative workers' compensation programs. Existing law limits the applicability of these provisions to employers engaged in construction, construction maintenance, or other related activities.

This bill would expand the applicability of these provisions by removing this industry limitation.

(4) Existing law defines injury for purposes of the workers' compensation program.

This bill would revise this definition. The bill would specify the conditions under which injuries are compensable under the workers'



compensation program. The bill would also provide that an injury sustained by a person while incarcerated or imprisoned in a county jail or the state prison is not compensable.

(5) Existing law defines physician for purposes of the workers' compensation program, to include among others, acupuncturists and chiropractic practitioners. Existing law provides that this definition does not authorize acupuncturists to determine disability for specified purposes under the workers' compensation program.

This bill would, instead, provide that an acupuncturist or chiropractic practitioner shall not determine disability for specified purposes under the workers' compensation program.

(6) Existing law establishes liability for compensation against an employer for the injury or death of an employee under specified circumstances, including where, at the time of the injury, both the employer and the employee are subject to the state's workers' compensation provisions.

This bill would include among these circumstances that establish liability for an employer circumstances where the employer and employee are not subject to a rule of liability for injury or death arising out of and in the course of employment provided by the laws of the United States.

(7) Existing law authorizes an employer to secure the payment of workers' compensation by securing from the Director of Industrial Relations a certificate of consent to self-insure either as an individual employer or as one employer in a group of employers upon proof satisfactory to the director of the ability to self-insure and to pay any compensation that may become due to employees.

This bill would establish procedures that would apply to private self-insurance groups upon certification by the Insurance Commissioner that these procedures meet prescribed criteria.

(8) Existing law establishes procedures under which medical evaluations may be performed that apply to disputes over the compensability of any injury. Evaluations performed under these provisions are not limited to the issue of the compensability of the injury, but may also address medical issues in dispute.

This bill would limit these evaluations to the issue of the compensability of the injury.

(9) Existing law establishes procedures with respect to disputes between employers and employees regarding the compensability of the injury and the extent and scope of medical treatment for that injury,



including procedures relating to obtaining medical-legal evaluations by qualified medical evaluators. Existing law creates a presumption in certain circumstances that the treating physician of an employee, who has been predesignated by the employee, is correct.

This bill would repeal this presumption, and would revise the procedures relating to medical-legal evaluations.

(10) Existing law requires an employer to provide to an employee who is injured on the job medical treatment that is reasonably required to cure or relieve from the effects of the injury.

This bill would define medical treatment that is reasonably required to cure or relieve from the effects of the injury and would apply this definition to all treatment requested on or after July 1, 2004, including treatment for injuries sustained prior to that date. The bill would make conforming changes.

(11) Existing law authorizes an employee to be treated by a physician or at a facility of his or her own choice within a reasonable geographic area after 30 days from the date the injury is reported. Existing law also authorizes an employee that has notified his or her employer in writing prior to the date of injury that he or she has a personal physician to be treated by that physician from the date of injury.

This bill, instead, would authorize these choices only if the selection of the physician or facility is mutually agreed to by the employer.

(12) Existing law provides for obtaining health coverage for workers' compensation from a health care organization, establishes certification requirements for those health care organizations, and limits the funds that may be received as a loan from the General Fund to support the administration of these provisions.

This bill would recast these provisions. Among other changes, the bill would revise the certification requirements and would delete the limitation on certain loans from the General Fund.

(13) Existing law requires an employer, upon the request of an employee, to tender the employee one change of physician, authorizes the employer to petition the administrative director for a change of physician, and establishes various obligations of an employee and employer once a physician is selected.

This bill would repeal these provisions.

(14) Chapter 639 of the Statutes of 2003 will require the administrative director, on or before December 1, 2004, to adopt, after public hearings, a medical treatment utilization schedule.



This bill would provide that this schedule would create a rebuttable presumption that the schedule adopted pursuant to those provisions is correct on the issue of extent and scope of medical treatment of a worker's injuries and that this presumption may be controverted. It would also provide that certain guidelines shall be presumptively correct on the issue of extent and scope of medical treatment of a worker's injuries for a specified period of time. The bill, notwithstanding the medical treatment utilization schedule and specified guidelines, would limit the number of chiropractic and physical therapy visits by an employee per industrial injury.

(15) Existing law, with respect to contracts providing for the payment of preferred reimbursement rates by payors for health care services rendered by health care providers, imposes certain disclosure and related requirements on contracting agents, as defined, who sell, lease, assign, transfer, or convey a list of contracting providers and their contracted preferred reimbursement rates to other payors or contracting agents. Existing law also imposes certain requirements on payors who seek to pay a preferred rate, and provides that the failure to comply with these requirements renders the payor liable to pay the nonpreferred rate.

This bill would repeal these provisions.

(16) Existing law establishes procedures with respect to disputes between employers and employees regarding the compensability of the injury and the extent and scope of medical treatment for that injury.

This bill would establish, commencing July 1, 2004, the Independent Medical Review System to resolve disputes involving any disputed health care service. The bill would authorize the Department of Industrial Relations to contract with one or more independent medical review organizations to conduct reviews for this purpose. The cost of the independent medical review under these provisions would be borne by the employer.

(17) Existing law limits the amount of fees payable to medical providers under contracts with the employee's health benefit program for health care services rendered to employees.

This bill would repeal those provisions.

(18) Existing law provides certain methods for determining workers' compensation benefits payable to a worker or his or her dependents for purposes of temporary disability, permanent total disability, permanent partial disability, and in case of death.

This bill would provide, with respect to an injury that causes permanent disability, extended benefits that would become operative



only if the Secretary of Labor and Workforce Development files a declaration that certain conditions exist with respect to the cost of workers' compensation insurance in California.

(19) Chapter 635 of the Statutes of 2003 will provide, with specified exceptions, that if an injury causes permanent partial disability and the injured employee does not return to work for the employer within 60 days of the termination of the temporary disability indemnity payments, the injured employee shall receive a supplemental job displacement benefit.

This bill would revise the exceptions.

(20) Existing workers' compensation law authorizes the administrative director to prepare, adopt, and from time to time amend a schedule for the determination of the percentage of permanent disabilities in accordance with specified provisions. Existing law provides that the schedule and amendments to the schedule apply prospectively.

This bill would require the administrative director to prepare, adopt, and amend the schedule. The bill would delete the provisions that would apply the schedule prospectively.

Existing law provides that when determining the percentages of permanent disability, account shall be taken of various factors, including the nature of the physical injury or disfigurement and with consideration being given to the diminished ability of the injured employee to compete in an open labor market.

This bill would require that the nature of the physical injury or disfigurement be established by a preponderance of medical evidence based upon objective findings, as defined, and would instead, require that consideration be given to the injured employee's adaptability to perform a given job. The bill would also require that the physical injury or disfigurement be the sole factor to be considered under certain circumstances.

(21) Existing law prescribes which party must bear the burden of proof in various aspects of workers' compensation proceedings.

This bill would provide that the burden of proof for apportionment regarding permanent disability shall rest on the defendant and would establish the standard of proof. This bill would also limit the accumulation of all permanent disability awards issued to one individual and would prohibit the payment of permanent disability and death benefits unless the industrial injury is the predominant cause of the disability or death when compared to all causes of injury in total.



(22) Existing law provides that when payment has been unreasonably delayed or refused, the full amount of the order, decision, or award shall be increased by 10%. Existing law requires the appeals board to determine the question of delay and reasonableness and to award reasonable attorney’s fees incurred in enforcing the payment of compensation awarded.

This bill would repeal these provisions. The bill would, instead, prescribe procedures under which, when the payment of compensation has been unreasonably delayed or refused, the amount of the payment unreasonably delayed or refused may be increased up to 15% or \$500, whichever is greater. The bill would require the appeals board to use its discretion to accomplish a fair balance and substantial justice between the parties.

(23) This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ²/₃. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1877.5 of the Insurance Code is
2 amended to read:
3 1877.5. No insurer, ~~or~~ agent authorized by an insurer to act on
4 its behalf, *or licensed rating organization* who furnishes
5 information, written or oral, pursuant to this article, and no
6 authorized governmental agency or its employees who (a)
7 furnishes or receives information, written or oral, pursuant to this
8 article, or (b) assists in any investigation of a suspected violation
9 of Section 1871.1, 1871.4, 11760, or 11880, or of Section 549 of
10 the Penal Code, or of Section 3215~~–or~~, 3219, *or 3823* of the Labor
11 Code conducted by an authorized governmental agency, shall be
12 subject to any civil liability in a cause or action of any kind where
13 the insurer, authorized agent, *licensed rating organization*, or
14 authorized governmental agency acts in good faith, without
15 malice, and reasonably believes that the action taken was
16 warranted by the then known facts, obtained by reasonable efforts.
17 Nothing in this chapter is intended to, nor does in any way or
18 manner, abrogate or lessen the existing common law or statutory
19 privileges and immunities of an insurer, agent authorized by that

[4]



1 insurer to act on its behalf, *licensed rating organization*, or any
2 authorized governmental agency or its employees.

3 SEC. 1.5. Chapter 5 (commencing with Section 110) of
4 Division 1 of the Labor Code is repealed.

5 SEC. 2. Part 1 (commencing with Section 3110) is added to
6 Division 4 of the Labor Code, to read:

7

8 PART 1. DIVISION OF WORKERS' COMPENSATION

9

10 3110. As used in this part the following definitions shall
11 apply:

12 (a) "Appeals board" means the Workers' Compensation
13 Appeals Board. The title of a member of the board is
14 "commissioner."

15 (b) "Administrative director" means the Administrative
16 Director of the Division of Workers' Compensation.

17 (c) "Division" means the Division of Workers' Compensation.

18 (d) "Medical director" means the physician appointed by the
19 administrative director pursuant to Section 3122.

20 (e) "Qualified medical evaluator" means physicians
21 appointed by the administrative director pursuant to Section
22 3139.2.

23 (f) "Court administrator" means the administrator of the
24 workers' compensation adjudicatory process at the trial level.

25 3111. (a) The Workers' Compensation Appeals Board,
26 consisting of seven members, shall exercise all judicial powers
27 vested in it under this code. In all other respects, the Division of
28 Workers' Compensation is under the control of the administrative
29 director and, except as to those duties, powers, jurisdiction,
30 responsibilities, and purposes as are specifically vested in the
31 appeals board, the administrative director shall exercise the
32 powers of the head of a department within the meaning of Article
33 1 (commencing with Section 11150) of Chapter 2 of Part 1 of
34 Division 3 of Title 2 of the Government Code with respect to the
35 Division of Workers' Compensation which shall include
36 supervision of, and responsibility for, personnel, and the
37 coordination of the work of the division, except personnel of the
38 appeals board.

39 (b) The administrative director shall prepare and submit, on
40 March 1 of each year, a report to the Governor and the Legislature



1 covering the activities of the division during the prior year. The
2 report shall include recommendations for improvement and the
3 need, if any, for legislation to enhance the delivery of
4 compensation to injured workers. The report shall include data on
5 penalties imposed on employers or insurers due to delays in
6 compensation or notices, or both, by category of penalty imposed.

7 3112. (a) The members of the appeals board shall be
8 appointed by the Governor with the advice and consent of the
9 Senate. The term of office of the members appointed prior to
10 January 1, 1990, shall be four years, and the term of office of
11 members appointed on or after January 1, 1990, shall be six years
12 and they shall hold office until the appointment and qualification
13 of their successors.

14 (b) Five of the members of the appeals board shall be
15 experienced attorneys at law admitted to practice in the State of
16 California. The other two members need not be attorneys at law.
17 All members shall be selected with due consideration of their
18 judicial temperament and abilities. Each member shall receive the
19 salary provided for by Chapter 6 (commencing with Section
20 11550) of Part 1 of Division 3 of Title 2 of the Government Code.

21 3113. (a) The Governor shall designate the chair of the
22 appeals board from the membership of the appeals board. The
23 person so designated shall hold the office of chair at the pleasure
24 of the Governor.

25 (b) The chair may designate in writing one of the other
26 members of the appeals board to act as chair during any time that
27 he or she may be absent from the state on official business, on
28 vacation, or absent due to illness.

29 3115. (a) Actions of the appeals board shall be taken by
30 decision of a majority of the appeals board except as otherwise
31 expressly provided.

32 (b) The chair shall assign pending cases in which
33 reconsideration is sought to any three members thereof for
34 hearing, consideration, and decision. Assignments by the chair of
35 members to these cases shall be rotated on a case-by-case basis
36 with the composition of the members so assigned being varied and
37 changed to assure that there shall never be a fixed and continued
38 composition of members. Any case assigned to any three members
39 in which the finding, order, decision, or award is made and filed
40 by any two or more of those members shall be the action of the



1 appeals board unless reconsideration is had in accordance with
2 Article 1 (commencing with Section 5900) of Chapter 7 of Part 4.
3 Any case assigned to three members shall be heard and decided
4 only by them, unless the matter has been reassigned by the chair
5 on a majority vote of the appeals board to the appeals board as a
6 whole in order to achieve uniformity of decision, or in cases
7 presenting novel issues.

8 3116. The seal of the appeals board bearing the inscription
9 “Workers’ Compensation Appeals Board, Seal” shall be affixed
10 to all writs and authentications of copies of records and to any other
11 instruments as the appeals board directs.

12 3117. The administrative director may appoint an attorney
13 licensed to practice law in the state as counsel to the division.

14 3119. The attorney shall do all of the following:

15 (a) Represent and appear for the state and the Division of
16 Workers’ Compensation and the appeals board in all actions and
17 proceedings arising under any provision of this code administered
18 by the division or under any order or act of the division or the
19 appeals board and, if directed, intervene, if possible, in any action
20 or proceeding in which any such question is involved.

21 (b) Commence, prosecute, and expedite the final determination
22 of all actions or proceedings, directed or authorized by the
23 administrative director or the appeals board.

24 (c) Advise the administrative director, the appeals board, and
25 each member of the appeals board, upon request, in regard to the
26 jurisdiction, powers, or duties of the administrative director, the
27 appeals board, and each member of the appeals board.

28 (d) Generally perform the duties and services as attorney to the
29 division and the appeals board that are required of him or her.

30 3120. The administrative director and the chair of the appeals
31 board may each respectively appoint a secretary and assistant
32 secretaries to perform services as prescribed under this part.

33 3121. The chair of the appeals board may authorize its
34 secretary and any two assistant secretaries to act as deputy appeals
35 board members and may delegate authority and duties to these
36 deputies. Not more than three deputies may act as appeals board
37 members at any one time. No act of any deputy shall be valid unless
38 it is concurred in by at least one member of the appeals board.

39 3122. The administrative director shall appoint a medical
40 director who shall possess a physician’s and surgeon’s certificate



1 granted under Chapter 5 (commencing with Section 2000) of
2 Division 2 of the Business and Professions Code. The medical
3 director shall employ medical assistants who shall also possess
4 physicians' and surgeons' certificates and other staff necessary to
5 the performance of his or her duties. The salaries for the medical
6 director and his or her assistants shall be fixed by the Department
7 of Personnel Administration, commensurate with the salaries paid
8 by private industry to medical directors and assistant medical
9 directors.

10 3123. The administrative director may employ necessary
11 assistants, officers, experts, statisticians, actuaries, accountants,
12 workers' compensation administrative law judges, stenographic
13 shorthand reporters, legal secretaries, disability evaluation raters,
14 program technicians, and other employees to implement new,
15 efficient court management systems. The salaries of the workers'
16 compensation administrative law judges shall be fixed by the
17 Department of Personnel Administration for a class of positions
18 that perform judicial functions.

19 3123.3. Any official reporter employed by the administrative
20 director shall render stenographic or clerical assistance as directed
21 by the presiding workers' compensation administrative law judge
22 of the office to which the reporter is assigned, when the presiding
23 workers' compensation administrative law judge determines that
24 the reporter is not engaged in the performance of any other duty
25 imposed by law.

26 3123.5. (a) Workers' compensation administrative law
27 judges employed by the administrative director and supervised by
28 the court administrator pursuant to this part shall be taken from an
29 eligible list of attorneys licensed to practice law in this state, who
30 have the qualifications prescribed by the State Personnel Board. In
31 establishing eligible lists for this purpose, state civil service
32 examinations shall be conducted in accordance with the State Civil
33 Service Act (Part 2 (commencing with Section 18500) of Division
34 5 of Title 2 of the Government Code). Every workers'
35 compensation judge shall maintain membership in the State Bar of
36 California during his or her tenure.

37 (b) All workers' compensation administrative law judges
38 appointed on or after January 1, 2003, shall be attorneys licensed
39 to practice law in California for five or more years prior to their



1 appointment and shall have experience in workers' compensation
2 law.

3 (c) A workers' compensation administrative law judge may not
4 receive his or her salary as a workers' compensation
5 administrative law judge while any cause before the workers'
6 compensation administrative law judge remains pending and
7 undetermined for 90 days after it has been submitted for decision.

8 3123.6. (a) All workers' compensation administrative law
9 judges employed by the administrative director and supervised by
10 the court administrator shall subscribe to the Code of Judicial
11 Ethics adopted by the Supreme Court pursuant to subdivision (m)
12 of Section 18 of Article VI of the California Constitution for the
13 conduct of judges and shall not otherwise, directly or indirectly,
14 engage in conduct contrary to that code or to the commentary to
15 the Code of Judicial Ethics made by the California Judges
16 Association.

17 (b) Honoraria or travel allowed by the court administrator, and
18 not otherwise prohibited by this section in connection with any
19 public or private conference, convention, meeting, social event, or
20 like gathering, the cost of which is significantly paid for by
21 attorneys who practice before the board, may not be accepted
22 unless the court administrator has provided prior approval in
23 writing to the workers' compensation administrative law judge
24 allowing him or her to accept those payments.

25 (c) In consultation with both the court administrator and the
26 Commission on Judicial Performance, the administrative director
27 shall adopt regulations to enforce this section. Existing regulations
28 shall remain in effect until new regulations based on the
29 recommendations of the court administrator and the Commission
30 on Judicial Performance have become effective. To the extent
31 possible, the regulations shall be consistent with the procedures
32 established by the Commission on Judicial Performance for
33 regulating the activities of state judges, and, to the extent possible,
34 with the gift, honoraria, and travel restrictions on legislators
35 contained in the Political Reform Act of 1974 (Title 9
36 commencing with Section 81000) of the Government Code). The
37 court administrator shall have the authority to enforce the
38 regulations adopted by the administrative director.

39 3123.7. The appeals board may, by rule or regulation,
40 establish procedures whereby attorneys who are either certified



1 specialists in workers' compensation by the California State Bar,
2 or are eligible for this certification, may be appointed by the
3 presiding workers' compensation judge of each board office to
4 serve as a pro tempore workers' compensation judge in a particular
5 case, upon the stipulation of the employee or his or her
6 representative, and the employer or the insurance carrier. Service
7 in this capacity by an attorney shall be voluntary and without pay.
8 It is the intent of the Legislature that the use of pro tempore
9 workers' compensation judges pursuant to this section shall not
10 result in a reduction of the number of permanent civil service
11 employees or the number of authorized full-time equivalent
12 positions.

13 3124. (a) In administering and enforcing this division, the
14 division shall protect the interests of injured workers who are
15 entitled to the timely provision of compensation.

16 (b) Forms and notices required to be given to employees by the
17 division shall be in English and Spanish.

18 3125. The administrative director shall cause to be printed
19 and furnished free of charge to any person blank forms that may
20 facilitate or promote the efficient performance of the duties of the
21 division.

22 3126. The division, including the administrative director and
23 the appeals board, shall keep minutes of all their proceedings and
24 other books or records requisite for proper and efficient
25 administration. All records shall be kept in their respective offices.

26 3127. The administrative director and court administrator
27 may do all of the following:

28 (a) Charge and collect fees for copies of papers and records, for
29 certified copies of official documents and orders or of the evidence
30 taken or proceedings had, for transcripts of testimony, and for
31 inspection of case files not stored in the place where the inspection
32 is requested. The administrative director shall fix those fees in an
33 amount sufficient to recover the actual costs of furnishing the
34 services. No fees for inspection of case files shall be charged to an
35 injured employee or his or her representative.

36 (b) Publish and distribute from time to time, in addition to the
37 reports to the Governor, further reports and pamphlets covering
38 the operations, proceedings, and matters relative to the work of the
39 division.



1 (c) Prepare, publish, and distribute an office manual, for which
2 a reasonable fee may be charged, and to which additions, deletions,
3 amendments, and other changes from time to time may be adopted,
4 published, and distributed, for which a reasonable fee may be
5 charged for the revision, or for which a reasonable fee may be fixed
6 on an annual subscription basis.

7 (d) Fix and collect reasonable charges for publications issued.
8 3127.5. In the exercise of his or her functions, the court
9 administrator shall further the interests of uniformity and
10 expedition of proceedings before workers' compensation
11 administrative law judges, ensure that all workers' compensation
12 administrative law judges are qualified and adhere to deadlines
13 mandated by law or regulation, and manage district office
14 procedural matters at the trial level.

15 3127.6. (a) The administrative director shall, in consultation
16 with the Commission on Health and Safety and Workers'
17 Compensation, other state agencies, and researchers and research
18 institutions with expertise in health care delivery and occupational
19 health care service, conduct a study of medical treatment provided
20 to workers who have sustained industrial injuries and illnesses.
21 The study shall focus on, but not be limited to, all of the following:

22 (1) Factors contributing to the rising costs and utilization of
23 medical treatment and case management in the workers'
24 compensation system.

25 (2) An evaluation of case management procedures that
26 contribute to or achieve early and sustained return to work within
27 the employee's temporary and permanent work restrictions.

28 (3) Performance measures for medical services that reflect
29 patient outcomes.

30 (4) Physician utilization, quality of care, and outcome
31 measurement data.

32 (5) Patient satisfaction.

33 (b) The administrative director shall begin the study on or
34 before July 1, 2003, and shall report and make recommendations
35 to the Legislature based on the results of the study on or before July
36 1, 2004.

37 (c) In implementing this section, the administrative director
38 shall ensure the confidentiality and protection of patient-specific
39 data.



1 3128. The appeals board may accept appointment as deputy
2 commissioner under, or accept any delegation of authority to
3 enforce, the United States Longshoremen's and Harbor Worker's
4 Compensation Act. The appeals board may enter into
5 arrangements with the United States, subject to the approval of the
6 Department of Finance, for the payment of any expenses incurred
7 in the performance of services under said act. In the performance
8 of any duties under that act, appointment, or authority, the appeals
9 board may, subject to the provisions thereof, exercise any
10 authority conferred upon the appeals board by the laws of this
11 state.

12 3129. (a) To make certain that injured workers, or their
13 dependents in the event of their death, receive promptly and
14 accurately the full measure of compensation to which they are
15 entitled, the administrative director shall audit insurers,
16 self-insured employers, and third-party administrators to
17 determine if they have met their obligations under this code. Each
18 audit subject shall be audited at least once every five years. The
19 audit subjects shall be selected and the audits conducted pursuant
20 to subdivision (b). The results of audits of insurers shall be
21 provided to the Insurance Commissioner, and the results of audits
22 of self-insurers and third-party administrators shall be provided to
23 the Director of Industrial Relations. Nothing in this section shall
24 restrict the authority of the Director of Industrial Relations or the
25 Insurance Commissioner to audit their licensees.

26 (b) The administrative director shall schedule and conduct
27 audits as follows:

28 (1) A profile audit review of every audit subject shall be
29 conducted once every five years and on additional occasions
30 indicated by target audit criteria. The administrative director shall
31 annually establish a profile audit review performance standard that
32 will identify the poorest performing audit subjects.

33 (2) A full compliance audit shall be conducted of each profile
34 audited subject failing to meet or exceed the profile audit review
35 performance standard. The full compliance audit shall be a
36 comprehensive and detailed evaluation of the audit subject's
37 performance. The administrative director shall annually establish
38 a full compliance audit performance standard that will identify the
39 audit subjects that are performing satisfactorily. Any full
40 compliance audit subject that fails to meet or exceed the full



1 compliance audit performance standard shall be audited again
2 within two years.

3 (3) A targeted profile audit review or a full compliance audit
4 may be conducted at any time in accordance with target audit
5 criteria adopted by the administrative director. The target audit
6 criteria shall be based on information obtained from benefit
7 notices, from information and assistance officers, and from other
8 reliable sources providing factual information that indicates an
9 insurer, self-insured employer, or third-party administrator is
10 failing to meet its obligations under this division or Division 4
11 (commencing with Section 3200) or the regulations of the
12 administrative director.

13 (c) (1) If, as a result of a profile audit review or a full
14 compliance audit, the administrative director determines that any
15 compensation, interest, or penalty is due and unpaid to an
16 employee or dependent, the administrative director shall issue and
17 cause to be served upon the insurer, self-insured employer, or
18 third-party administrator a notice of assessment detailing the
19 amounts due and unpaid in each case, and shall order the amounts
20 paid to the person entitled thereto. The notice of assessment shall
21 be served personally or by registered mail in accordance with
22 subdivision (c) of Section 11505 of the Government Code. A copy
23 of the notice of assessment shall also be sent to the affected
24 employee or dependent.

25 (2) If the amounts are not paid within 30 days after service of
26 the notice of assessment, the employer shall also be liable for
27 reasonable attorney's fees necessarily incurred by the employee or
28 dependent to obtain amounts due. The administrative director
29 shall advise each employee or dependent still owed compensation
30 after this 30-day period of his or her rights with respect to the
31 commencement of proceedings to collect the compensation owed.
32 Amounts unpaid because the person entitled thereto cannot be
33 located shall be paid to the Workers' Compensation
34 Administration Revolving Fund. The Director of Industrial
35 Relations shall adopt rules and regulations establishing standards
36 and procedures for the payment of compensation from moneys
37 deposited in the Workers' Compensation Administration
38 Revolving Fund whenever the person entitled thereto applies for
39 compensation.



1 (d) A determination by the administrative director that an
2 amount is or is not due to an employee or dependent shall not in
3 any manner limit the jurisdiction or authority of the appeals board
4 to determine the issue.

5 (e) Annually, commencing on April 1, 1991, the administrative
6 director shall publish a report detailing the results of audits
7 conducted pursuant to this section during the preceding calendar
8 year. The report shall include the name of each insurer,
9 self-insured employer, and third-party administrator audited
10 during that period. For each insurer, self-insured employer, and
11 third-party administrator audited, the report shall specify the total
12 number of files audited, the number of violations found by type
13 and amount of compensation, interest and penalties payable, and
14 the amount collected for each violation. The report shall not
15 identify the particular claim file that resulted in a particular
16 violation or penalty. Except as required by this subdivision or other
17 provisions of law, the contents of individual claim files and
18 auditor's working papers shall be confidential. Disclosure of claim
19 information to the administrative director pursuant to an audit
20 shall not waive the provisions of the Evidence Code relating to
21 privilege.

22 (f) The administrative director shall also publish and make
23 available to the public on request a list ranking all insurers,
24 self-insured employers, and third-party administrators audited
25 during the period according to their performance measured by the
26 profile audit review and full compliance audit performance
27 standards.

28 (g) A profile audit review of the adjustment of claims against
29 the Uninsured Employers Fund by the claims and collections unit
30 of the Division of Workers' Compensation shall be conducted at
31 least every five years. The results of this profile audit review shall
32 be included in the report required by subdivision (e).

33 3129.5. (a) The administrative director may assess an
34 administrative penalty against an insurer, self-insured employer,
35 or third-party administrator for any of the following:

36 (1) Failure to comply with the notice of assessment issued
37 pursuant to subdivision (c) of Section 3129 within 15 days of
38 receipt.

39 (2) Failure to pay when due the undisputed portion of an
40 indemnity payment, the reasonable cost of medical treatment of an



1 injured worker, or a charge or cost implementing an approved
2 vocational rehabilitation plan.

3 (3) Failure to comply with any rule or regulation of the
4 administrative director.

5 (b) The administrative director shall adopt regulations
6 establishing a schedule of violations and the amount of the
7 administrative penalty to be imposed for each type of violation.
8 The schedule shall provide for imposition of a penalty of up to one
9 hundred dollars (\$100) for each violation of the less serious type
10 and for imposition of penalties in progressively higher amounts for
11 the most serious types of violations to be set at up to five thousand
12 dollars (\$5,000) per violation. The administrative director is
13 authorized to impose penalties pursuant to rules and regulations
14 that give due consideration to the appropriateness of the penalty
15 with respect to the following factors:

- 16 (1) The gravity of the violation.
- 17 (2) The good faith of the insurer, self-insured employer, or
18 third-party administrator.
- 19 (3) The history of previous violations, if any.
- 20 (4) The frequency of the violations.
- 21 (5) Whether the audit subject has met or exceeded the profile
22 audit review performance standard.
- 23 (6) Whether a full compliance audit subject has met or
24 exceeded the full compliance audit performance standard.
- 25 (7) The size of the audit subject location.

26 (c) The administrative director shall assess penalties as
27 follows:

- 28 (1) If, after a profile audit review, the administrative director
29 determines that the profile audit subject met or exceeded the
30 profile audit review performance standard, no penalties shall be
31 assessed under this section, but the audit subject shall be required
32 to pay any compensation due and penalties due under subdivision
33 (d) of Section 4650 as provided in subdivision (c) of Section 3129.
- 34 (2) If, after a full compliance audit, the administrative director
35 determines that the audit subject met or exceeded the full
36 compliance audit performance standards, penalties for unpaid or
37 late paid compensation, but no other penalties under this section,
38 shall be assessed. The audit subject shall be required to pay any
39 compensation due and penalties due under subdivision (d) of
40 Section 4650 as provided in subdivision (c) of Section 3129.



1 (3) If, after a full compliance audit, the administrative director
2 determines that the audit subject failed to meet the full compliance
3 audit performance standards, penalties shall be assessed as
4 provided in a full compliance audit failure penalty schedule to be
5 adopted by the administrative director. The full compliance audit
6 failure penalty schedule shall adjust penalty levels relative to the
7 size of the audit location to mitigate inequality between total
8 penalties assessed against small and large audit subjects. The
9 penalty amounts provided in the full compliance audit failure
10 penalty schedule for the most serious type of violations shall not
11 be limited by subdivision (b), but in no event shall the penalty for
12 a single violation exceed forty thousand dollars (\$40,000).

13 (d) The notice of penalty assessment shall be served personally
14 or by registered mail in accordance with subdivision (c) of Section
15 11505 of the Government Code. The notice shall be in writing and
16 shall describe the nature of the violation, including reference to the
17 statutory provision or rule or regulation alleged to have been
18 violated. The notice shall become final and the assessment shall be
19 paid unless contested within 15 days of receipt by the insurer,
20 self-insured employer, or third-party administrator.

21 (e) (1) In addition to the penalty assessments permitted by
22 subdivisions (a), (b), and (c), the administrative director may
23 assess a civil penalty, not to exceed one hundred thousand dollars
24 (\$100,000), upon finding, after hearing, that an employer, insurer,
25 or third-party administrator for an employer has knowingly
26 committed or performed with sufficient frequency so as to indicate
27 a general business practice any of the following:

28 (A) Induced employees to accept less than compensation due,
29 or made it necessary for employees to resort to proceedings against
30 the employer to secure compensation.

31 (B) Refused to comply with known and legally indisputable
32 compensation obligations.

33 (C) Discharged or administered compensation obligations in a
34 dishonest manner.

35 (D) Discharged or administered compensation obligations in a
36 manner as to cause injury to the public or those dealing with the
37 employer or insurer.

38 (2) Any employer, insurer, or third-party administrator that
39 fails to meet the full compliance audit performance standards in
40 two consecutive full compliance audits shall be rebuttably



1 presumed to have engaged in a general business practice of
2 discharging and administering its compensation obligations in a
3 manner causing injury to those dealing with it.

4 (3) Upon a second or subsequent finding, the administrative
5 director shall refer the matter to the Insurance Commissioner or the
6 Director of Industrial Relations and request that a hearing be
7 conducted to determine whether the certificate of authority,
8 certificate of consent to self-insure, or certificate of consent to
9 administer claims of self-insured employers, as the case may be,
10 shall be revoked.

11 (f) An insurer, self-insured employer, or third-party
12 administrator may file a written request for a conference with the
13 administrative director within seven days after receipt of a notice
14 of penalty assessment issued pursuant to subdivision (a) or (c).
15 Within 15 days of the conference, the administrative director shall
16 issue a notice of findings and serve it upon the contesting party by
17 registered or certified mail. Any amount found due by the
18 administrative director shall become due and payable 30 days after
19 receipt of the notice of findings. The 30-day period shall be tolled
20 during any appeal. A writ of mandate may be taken from the
21 findings to the appropriate superior court upon the execution by
22 the contesting party of a bond to the state in the principal sum that
23 is double the amount found due and ordered by the administrative
24 director, on the condition that the contesting party shall pay any
25 judgment and costs rendered against it for the amount.

26 (g) (1) An insurer, self-insured employer, or third-party
27 administrator may file a written request for a hearing before the
28 appeals board within seven days after receipt of a notice of penalty
29 assessment issued pursuant to subdivision (e).

30 (2) Within 30 days of the hearing, the appeals board shall issue
31 findings and orders and serve them upon the contesting party in the
32 manner provided in its rules. Any amount found due by the appeals
33 board shall become due and payable 45 days after receipt of the
34 notice of findings. Judicial review of the findings and order shall
35 be had in the manner provided by Article 2 (commencing with
36 Section 5950) of Chapter 7 of Part 4 of Division 4. The 45-day
37 period shall be tolled during appellate proceedings upon execution
38 by the contesting party of a bond to the state in a principal sum that
39 is double the amount found due and ordered by the appeals board
40 on the condition that the contesting party shall pay the amount



1 ultimately determined to be due and any costs awarded by an
2 appellate court.

3 (h) Nothing in this section shall create nor eliminate a civil
4 cause of action for the employee and his or her dependents.

5 (i) All moneys collected under this section shall be deposited
6 in the State Treasury and credited to the Workers' Compensation
7 Administration Revolving Fund.

8 3130. The appeals board and each of its members, and its
9 secretary, assistant secretaries, and workers' compensation judges,
10 may administer oaths, certify to all official acts, and issue
11 subpoenas for the attendance of witnesses and the production of
12 papers, books, accounts, documents, and testimony in any inquiry,
13 investigation, hearing, or proceeding in any part of the state.

14 3131. Each witness who appears by order of the appeals board
15 or any of its members, or a workers' compensation judge, shall
16 receive, if demanded, for his or her attendance the same fees and
17 mileage allowed by law to a witness in civil cases, paid by the party
18 at whose request the witness is subpoenaed, unless otherwise
19 ordered by the appeals board. When any witness who has not been
20 required to attend at the request of any party is subpoenaed by the
21 appeals board, his or her fees and mileage may be paid from the
22 funds appropriated for the use of the appeals board in the same
23 manner as other expenses of the appeals board are paid. Any
24 witness subpoenaed, except one whose fees and mileage are paid
25 from the funds of the appeals board, may, at the time of service,
26 demand the fee to which he or she is entitled for travel to and from
27 the place at which he or she is required to appear, and one day's
28 attendance. If a witness demands his or her fees at the time of
29 service, and they are not at that time paid or tendered, he or she
30 shall not be required to attend as directed in the subpoena. All fees
31 and mileage to which any witness is entitled under this section may
32 be collected by action therefor instituted by the person to whom the
33 fees are payable.

34 3132. The superior court in and for the county in which any
35 proceeding is held by the appeals board or a workers'
36 compensation judge may compel the attendance of witnesses, the
37 giving of testimony and the production of papers, including books,
38 accounts, and documents, as required by any subpoena regularly
39 issued under this part. In case of the refusal of any witness to obey
40 the subpoena the appeals board or the workers' compensation



1 judge, before whom the testimony is to be given or produced, may
 2 report to the superior court in and for the county in which the
 3 proceeding is pending, by petition, setting forth that due notice has
 4 been given of the time and place of attendance of the witness, or
 5 the production of the papers, that the witness has been subpoenaed
 6 in the prescribed manner, and that the witness has failed and
 7 refused to obey the subpoena, or has refused to answer questions
 8 propounded to him or her in the course of the proceeding, and ask
 9 an order of the court, compelling the witness to attend and testify
 10 or produce the papers before the appeals board. The court shall
 11 thereupon enter an order directing the witness to appear before the
 12 court at a time and place fixed in the order, the time to be not more
 13 than 10 days from the date of the order, and then and there show
 14 cause why he or she had not attended and testified or produced the
 15 papers before the appeals board or the workers' compensation
 16 judge. A copy of the order shall be served upon the witness. If it
 17 appears to the court that the subpoena was regularly issued under
 18 this part and that the witness was legally bound to comply
 19 therewith, the court shall thereupon enter an order that the witness
 20 appear before the appeals board or the workers' compensation
 21 judge at a time and place fixed in the order, and testify or produce
 22 the required papers, and upon failure to obey the order, the witness
 23 shall be dealt with as for contempt of court. The remedy provided
 24 in this section is cumulative, and shall not impair or interfere with
 25 the power of the appeals board or a member thereof to enforce the
 26 attendance of witnesses and the production of papers, and to
 27 punish for contempt in the same manner and to the same extent as
 28 courts of record.

29 3132.5. (a) It is the declared policy of this state that there
 30 should not be discrimination against workers who are injured in
 31 the course and scope of their employment.

32 (b) Any employer who discharges, or threatens to discharge, or
 33 in any manner discriminates against any employee because he or
 34 she has filed or made known his or her intention to file a claim for
 35 compensation with his or her employer or an application for
 36 adjudication, or because the employee has received a rating,
 37 award, or settlement, is guilty of a misdemeanor and the
 38 employee's compensation shall be increased by one-half, but in no
 39 event more than ten thousand dollars (\$10,000), together with
 40 costs and expenses not in excess of two hundred fifty dollars

[4]



1 (\$250). The employee shall also be entitled to reinstatement and
2 reimbursement for lost wages and work benefits caused by the acts
3 of the employer.

4 (c) Any insurer that advises, directs, or threatens an insured
5 under penalty of cancellation or a raise in premium or for any other
6 reason, to discharge an employee because he or she has filed or
7 made known his or her intention to file a claim for compensation
8 with his or her employer or an application for adjudication, or
9 because the employee has received a rating, award, or settlement,
10 is guilty of a misdemeanor and subject to the increased
11 compensation and costs provided in subdivision (b).

12 (d) Any employer who discharges, or threatens to discharge, or
13 in any manner discriminates against any employee because the
14 employee testified or made known his or her intentions to testify
15 in another employee's case before the appeals board, is guilty of
16 a misdemeanor, and the employee shall be entitled to reinstatement
17 and reimbursement for lost wages and work benefits caused by the
18 acts of the employer.

19 (e) Any insurer that advises, directs, or threatens an insured
20 employer under penalty of cancellation or a raise in premium or
21 for any other reason, to discharge or in any manner discriminate
22 against an employee because the employee testified or made
23 known his or her intention to testify in another employee's case
24 before the appeals board, is guilty of a misdemeanor.

25 (f) Proceedings for increased compensation as provided in
26 subdivision (b), or for reinstatement and reimbursement for lost
27 wages and work benefits, are to be instituted by filing an
28 appropriate petition with the appeals board, but these proceedings
29 may not be commenced more than one year from the
30 discriminatory act or date of termination of the employee. The
31 appeals board is vested with full power, authority, and jurisdiction
32 to try and determine finally all matters specified in this section
33 subject only to judicial review, except that the appeals board shall
34 have no jurisdiction to try and determine a misdemeanor charge.
35 The appeals board may refer and any worker may complain of
36 suspected violations of the criminal misdemeanor provisions of
37 this section to the Division of Labor Standards Enforcement, or
38 directly to the office of the public prosecutor.

39 3133. The division, including the administrative director, the
40 court administrator, and the appeals board, shall have power and



1 jurisdiction to do all things necessary or convenient in the exercise
2 of any power or jurisdiction conferred upon it under this code.

3 3134. The appeals board or any member thereof may issue
4 writs or summons, warrants of attachment, warrants of
5 commitment, and all necessary process in proceedings for
6 contempt, in like manner and to the same extent as courts of record.
7 The process issued by the appeals board or any member thereof
8 shall extend to all parts of the state and may be served by any
9 persons authorized to serve process of courts of record or by any
10 person designated for that purpose by the appeals board or any
11 member thereof. The person executing process shall receive
12 compensation allowed by the appeals board, not to exceed the fees
13 prescribed by law for similar services. The fees shall be paid in the
14 same manner as provided Section 3131 for the fees of witnesses.

15 3135. In accordance with rules of practice and procedure that
16 it may adopt, the appeals board may, with the approval of the
17 Department of Finance, destroy or otherwise dispose of any file
18 kept by it in connection with any proceeding under this division or
19 Division 4.5 (commencing with Section 6100).

20 3138. The administrative director and the court administrator
21 may each appoint a deputy to act during that time as he or she may
22 be absent from the state due to official business, vacation, or
23 illness.

24 3138.1. (a) The administrative director shall be appointed by
25 the Governor with the advice and consent of the Senate and shall
26 hold office at the pleasure of the Governor. He or she shall receive
27 the salary provided for by Chapter 6 (commencing with Section
28 11550) of Part 1 of Division 3 of Title 2 of the Government Code.

29 (b) The court administrator shall be appointed by the Governor
30 with the advice and consent of the Senate. The court administrator
31 shall hold office at the pleasure of the administrative director. The
32 court administrator shall receive the salary provided for by
33 Chapter 6 (commencing with Section 11550) of Part 1 of Division
34 3 of Title 2 of the Government Code.

35 3138.2. (a) The headquarters of the division shall be based at
36 and operated from a centrally located city. The administrative
37 director and the court administrator shall have an office in that city
38 with suitable rooms, necessary office furniture, stationery, and
39 supplies, and may rent quarters in other places for the purpose of
40 establishing branch or service offices, and for that purpose may



1 provide those offices with necessary furniture, stationery, and
2 supplies.

3 (b) The administrative director shall provide suitable rooms,
4 with necessary office furniture, stationery, and supplies, for the
5 appeals board at the centrally located city in which the board shall
6 be based and from which it shall operate, and may rent quarters in
7 other places for the purpose of establishing branch or service
8 offices for the appeals board, and for that purpose may provide
9 those offices with necessary furniture, stationery, and supplies.

10 (c) All meetings held by the administrative director shall be
11 open and public. Notice thereof shall be published in papers of
12 general circulation not more than 30 days and not less than 10 days
13 prior to each meeting in Sacramento, San Francisco, Fresno, Los
14 Angeles, and San Diego. Written notice of all meetings shall be
15 given to all persons who request in writing directed to the
16 administrative director that they be given notice.

17 3138.3. The administrative director shall, with respect to all
18 injuries, adopt, in accordance with Section 5402, reasonable rules
19 and regulations requiring the employer to serve notice on the
20 injured employee that he or she may be entitled to benefits under
21 this division.

22 3138.4. (a) For the purpose of this section, “claims
23 administrator” means a self-administered workers’ compensation
24 insurer, self-administered self-insured employer,
25 self-administered legally uninsured employer, or
26 self-administered joint powers authority, or a third-party claims
27 administrator for an insurer, self-insured employer, legally
28 uninsured employer, or joint powers authority.

29 (b) With respect to injuries resulting in lost time beyond the
30 employee’s work shift at the time of injury or medical treatment
31 beyond first aid the following shall apply:

32 (1) If the claims administrator obtains knowledge that the
33 employer has not provided a claim form or a notice of potential
34 eligibility for benefits to the employee, it shall provide the form
35 and notice to the employee within three working days of its
36 knowledge that the form or notice was not provided.

37 (2) If the claims administrator cannot determine if the
38 employer has provided a claim form and notice of potential
39 eligibility for benefits to the employee, the claims administrator



1 shall provide the form and notice to the employee within 30 days
2 of the administrator's date of knowledge of the claim.

3 (c) The administrative director shall adopt reasonable rules and
4 regulations for serving on the employee or the employee's
5 dependents, in the case of death, notices dealing with the payment,
6 nonpayment, or delay in payment of temporary disability,
7 permanent disability, and death benefits and the provision of
8 vocational rehabilitation services and notices of any change in the
9 amount or type of benefits being provided, the termination of
10 benefits, the rejection of any liability for compensation, and an
11 accounting of benefits paid.

12 3138.5. (a) The division shall cooperate in the enforcement
13 of child support obligations. At the request of the Department of
14 Child Support Services, the administrative director shall assist in
15 providing to the State Department of Child Support Services
16 information concerning persons who are receiving permanent
17 disability benefits or who have filed an application for
18 adjudication of a claim that the Department of Child Support
19 Services determines is necessary to carry out its responsibilities
20 pursuant to Section 17510 of the Family Code.

21 (b) The process of sharing information with regard to
22 applicants for and recipients of permanent disability benefits
23 required by this section shall be known as the Workers'
24 Compensation Notification Project.

25 3138.6. (a) The administrative director, in consultation with
26 the Insurance Commissioner and the Workers' Compensation
27 Insurance Rating Bureau, shall develop a cost-efficient workers'
28 compensation information system that shall be administered by
29 the division. The administrative director shall adopt regulations
30 specifying the data elements to be collected by electronic data
31 interchange.

32 (b) The information system shall do all of the following:

33 (1) Assist the department to manage the workers'
34 compensation system in an effective and efficient manner.

35 (2) Facilitate the evaluation of the efficiency and effectiveness
36 of the benefit delivery system.

37 (3) Assist in measuring how adequately the system indemnifies
38 injured workers and their dependents.

39 (4) Provide statistical data for research into specific aspects of
40 the workers' compensation program.



1 (c) The data collected electronically shall be compatible with
2 the Electronic Data Interchange System of the International
3 Association of Industrial Accident Boards and Commissions. The
4 administrative director may adopt regulations authorizing the use
5 of other nationally recognized data transmission formats in
6 addition to those set forth in the Electronic Data Interchange
7 System for the transmission of data required pursuant to this
8 section. The administrative director shall accept data
9 transmissions in any authorized format. If the administrative
10 director determines that any authorized data transmission format
11 is not in general use by claims administrators, conflicts with the
12 requirements of state or federal law, or is obsolete, the
13 administrative director may adopt regulations eliminating that
14 data transmission format from those authorized pursuant to this
15 subdivision.

16 3138.7. (a) Except as expressly permitted in subdivision (b),
17 a person or public or private entity not a party to a claim for
18 workers' compensation benefits may not obtain individually
19 identifiable information obtained or maintained by the division on
20 that claim. For purposes of this section, "individually identifiable
21 information" means any data concerning an injury or claim that
22 is linked to a uniquely identifiable employee, employer, claims
23 administrator, or any other person or entity.

24 (b) (1) The administrative director, or a statistical agent
25 designated by the administrative director, may use individually
26 identifiable information for purposes of creating and maintaining
27 the workers' compensation information system as specified in
28 Section 3138.6.

29 (2) The State Department of Health Services may use
30 individually identifiable information for purposes of establishing
31 and maintaining a program on occupational health and
32 occupational disease prevention as specified in Section 105175 of
33 the Health and Safety Code.

34 (3) (A) Individually identifiable information may be used by
35 the division, the Division of Occupational Safety and Health, and
36 the Division of Labor Statistics and Research as necessary to carry
37 out their duties. The administrative director shall adopt regulations
38 governing the access to the information described in this
39 subdivision by these divisions. These regulations shall set forth the
40 specific uses for which this information may be obtained.



1 (B) Individually identifiable information maintained in the
2 workers' compensation information system and the division may
3 be used by researchers employed by or under contract to the
4 Commission on Health and Safety and Workers' Compensation as
5 necessary to carry out the commission's research. The
6 administrative director shall adopt regulations governing the
7 access to the information described in this subdivision by
8 commission researchers. These regulations shall set forth the
9 specific uses for which this information may be obtained and
10 include provisions guaranteeing the confidentiality of individually
11 identifiable information. Individually identifiable information
12 obtained under this subdivision shall not be disclosed to
13 commission members. No individually identifiable information
14 obtained by researchers under contract to the commission pursuant
15 to this subparagraph may be disclosed to any other person or entity,
16 public or private, for a use other than that research project for
17 which the information was obtained. Within a reasonable period
18 of time after the research for which the information was obtained
19 has been completed, the data collected shall be modified in a
20 manner so that the subjects cannot be identified, directly or
21 through identifiers linked to the subjects.

22 (4) The administrative director shall adopt regulations
23 allowing reasonable access to individually identifiable
24 information by other persons or public or private entities for the
25 purpose of bona fide statistical research. This research shall not
26 divulge individually identifiable information concerning a
27 particular employee, employer, claims administrator, or any other
28 person or entity. The regulations adopted pursuant to this
29 paragraph shall include provisions guaranteeing the
30 confidentiality of individually identifiable information. Within a
31 reasonable period of time after the research for which the
32 information was obtained has been completed, the data collected
33 shall be modified in a manner so that the subjects cannot be
34 identified, directly or through identifiers linked to the subjects.

35 (5) This section shall not operate to exempt from disclosure any
36 information that is considered to be a public record pursuant to the
37 California Public Records Act (Chapter 3.5 (commencing with
38 Section 6250) of Division 7 of Title 1 of the Government Code)
39 contained in an individual's file once an application for
40 adjudication has been filed pursuant to Section 5501.5.



1 However, individually identifiable information shall not be
2 provided to any person or public or private entity who is not a party
3 to the claim unless that person identifies himself or herself or that
4 public or private entity identifies itself and states the reason for
5 making the request. The administrative director may require the
6 person or public or private entity making the request to produce
7 information to verify that the name and address of the requester is
8 valid and correct. If the purpose of the request is related to
9 preemployment screening, the administrative director shall notify
10 the person about whom the information is requested that the
11 information was provided and shall include the following in
12 12-point type:

13 “IT MAY BE A VIOLATION OF FEDERAL AND STATE
14 LAW TO DISCRIMINATE AGAINST A JOB APPLICANT
15 BECAUSE THE APPLICANT HAS FILED A CLAIM FOR
16 WORKERS’ COMPENSATION BENEFITS.”

17 Any residence address is confidential and shall not be disclosed
18 to any person or public or private entity except to a party to the
19 claim, a law enforcement agency, an office of a district attorney,
20 any person for a journalistic purpose, or other governmental
21 agency.

22 Nothing in this paragraph shall be construed to prohibit the use
23 of individually identifiable information for purposes of
24 identifying bona fide lien claimants.

25 (c) Except as provided in subdivision (b), individually
26 identifiable information obtained by the division is privileged and
27 is not subject to subpoena in a civil proceeding unless, after
28 reasonable notice to the division and a hearing, a court determines
29 that the public interest and the intent of this section will not be
30 jeopardized by disclosure of the information. This section shall not
31 operate to restrict access to information by any law enforcement
32 agency or district attorney’s office or to limit admissibility of that
33 information in a criminal proceeding.

34 (d) It shall be unlawful for any person who has received
35 individually identifiable information from the division pursuant to
36 this section to provide that information to any person who is not
37 entitled to it under this section.

38 3139.2. (a) The administrative director shall appoint
39 qualified medical evaluators in each of the respective specialties



1 as required for the evaluation of medical-legal issues. The
2 appointments shall be for two-year terms.

3 (b) The administrative director shall appoint or reappoint as a
4 qualified medical evaluator a physician, as defined in Section
5 3209.3, who is licensed to practice in this state and who
6 demonstrates that he or she meets the requirements in paragraphs
7 (1), (2), (6), and (7), and, if the physician is a medical doctor,
8 doctor of osteopathy, doctor of chiropractic, or a psychologist, that
9 he or she also meets the applicable requirements in paragraph (3),
10 (4), or (5).

11 (1) Prior to his or her appointment as a qualified medical
12 evaluator, passes an examination written and administered by the
13 administrative director for the purpose of demonstrating
14 competence in evaluating medical-legal issues in the workers'
15 compensation system. Physicians shall not be required to pass an
16 additional examination as a condition of reappointment. A
17 physician seeking appointment as a qualified medical evaluator on
18 or after January 1, 2001, shall also complete prior to appointment,
19 a course on disability evaluation report writing approved by the
20 administrative director. The administrative director shall specify
21 the curriculum to be covered by disability evaluation report
22 writing courses, which shall include, but is not limited to, 12 or
23 more hours of instruction.

24 (2) Devotes at least one-third of total practice time to providing
25 direct medical treatment, or has served as an agreed medical
26 evaluator on eight or more occasions in the 12 months prior to
27 applying to be appointed as a qualified medical evaluator.

28 (3) Is a medical doctor or doctor of osteopathy and meets one
29 of the following requirements:

30 (A) Is board certified in a specialty by a board recognized by
31 the administrative director and either the Medical Board of
32 California or the Osteopathic Medical Board of California.

33 (B) Has successfully completed a residency training program
34 accredited by the American College of Graduate Medical
35 Education or the osteopathic equivalent.

36 (C) Was an active qualified medical evaluator on June 30,
37 2000.

38 (D) Has qualifications that the administrative director and
39 either the Medical Board of California or the Osteopathic Medical



1 Board of California, as appropriate, both deem to be equivalent to
2 board certification in a specialty.

3 (4) Is a doctor of chiropractic and meets either of the following
4 requirements:

5 (A) Has completed a chiropractic postgraduate specialty
6 program of a minimum of 300 hours taught by a school or college
7 recognized by the administrative director, the Board of
8 Chiropractic Examiners, and the Council on Chiropractic
9 Education.

10 (B) Has been certified in California workers' compensation
11 evaluation by a provider recognized by the administrative director.
12 The certification program shall include instruction on disability
13 evaluation report writing that meets the standards set forth in
14 paragraph (1).

15 (5) Is a psychologist and meets one of the following
16 requirements:

17 (A) Is board certified in clinical psychology by a board
18 recognized by the administrative director.

19 (B) Holds a doctoral degree in psychology, or a doctoral degree
20 deemed equivalent for licensure by the Board of Psychology
21 pursuant to Section 2914 of the Business and Professions Code,
22 from a university or professional school recognized by the
23 administrative director and has not less than five years'
24 postdoctoral experience in the diagnosis and treatment of
25 emotional and mental disorders.

26 (C) Has not less than five years' postdoctoral experience in the
27 diagnosis and treatment of emotional and mental disorders, and
28 has served as an agreed medical evaluator on eight or more
29 occasions prior to January 1, 1990.

30 (6) Does not have a conflict of interest as determined under the
31 regulations adopted by the administrative director pursuant to
32 subdivision (o).

33 (7) Meets any additional medical or professional standards
34 adopted pursuant to paragraph (6) of subdivision (j).

35 (c) The administrative director shall adopt standards for
36 appointment of physicians who are retired or who hold teaching
37 positions who are exceptionally well qualified to serve as a
38 qualified medical evaluator even though they do not otherwise
39 qualify under paragraph (2) of subdivision (b). In no event shall
40 a physician whose full-time practice is limited to the forensic



1 evaluation of disability be appointed as a qualified medical
2 evaluator under this subdivision.

3 (d) (1) The qualified medical evaluator, upon request, shall be
4 reappointed if he or she meets the qualifications of subdivision (b)
5 and meets all of the following criteria:

6 (A) Is in compliance with all applicable regulations and
7 evaluation guidelines adopted by the administrative director.

8 (B) Has not had more than five of his or her evaluations that
9 were considered by a workers' compensation judge at a contested
10 hearing rejected by the judge or the appeals board pursuant to this
11 section during the most recent two-year period during which the
12 physician served as a qualified medical evaluator. If the judge or
13 the appeals board rejects the qualified medical evaluator's report
14 on the basis that it fails to meet the minimum standards for those
15 reports established by the administrative director or the appeals
16 board, the judge or the appeals board, as the case may be, shall
17 make a specific finding to that effect, and shall give notice to the
18 medical evaluator and to the administrative director. Any rejection
19 shall not be counted as one of the five qualifying rejections until
20 the specific finding has become final and time for appeal has
21 expired.

22 (C) Has completed within the previous 24 months at least 12
23 hours of continuing education in impairment evaluation or
24 workers' compensation-related medical dispute evaluation
25 approved by the administrative director.

26 (D) Has not been terminated, suspended, placed on probation,
27 or otherwise disciplined by the administrative director during his
28 or her most recent term as a qualified medical evaluator.

29 (2) If the evaluator does not meet any one of the criteria
30 specified in paragraph (1), the administrative director may in his
31 or her discretion reappoint or deny reappointment according to
32 regulations adopted by the administrative director. In no event may
33 a physician who does not currently meet the requirements for
34 initial appointment or who has been terminated under subdivision
35 (e) because his or her license has been revoked or terminated by
36 the licensing authority be reappointed.

37 (e) The administrative director may, in his or her discretion,
38 suspend or terminate a qualified medical evaluator during his or
39 her term of appointment without a hearing as provided under



1 subdivision (k) or (l) whenever either of the following conditions
2 occurs:

3 (1) The evaluator's license to practice in California has been
4 suspended by the relevant licensing authority so as to preclude
5 practice, or has been revoked or terminated by the licensing
6 authority.

7 (2) The evaluator has failed to timely pay the fee required by
8 the administrative director pursuant to subdivision (n).

9 (f) The administrative director shall furnish a physician, upon
10 request, with a written statement of his or her reasons for
11 termination of, or for denying appointment or reappointment as,
12 a qualified medical evaluator. Upon receipt of a specific response
13 to the statement of reasons, the administrative director shall review
14 his or her decision not to appoint or reappoint the physician or to
15 terminate the physician and shall notify the physician of his or her
16 final decision within 60 days after receipt of the physician's
17 response.

18 (g) The administrative director shall establish agreements with
19 qualified medical evaluators to assure the expeditious evaluation
20 of cases assigned to them for comprehensive medical evaluations.

21 (h) (1) When the injured worker is not represented by an
22 attorney, the medical director appointed pursuant to Section 3122,
23 shall assign three-member panels of qualified medical evaluators
24 within five working days after receiving a request for a panel. If
25 a panel is not assigned within 15 working days, the employee shall
26 have the right to obtain a medical evaluation from any qualified
27 medical evaluator of his or her choice. The medical director shall
28 use a random selection method for assigning panels of qualified
29 medical evaluators. The medical director shall select evaluators
30 who are specialists whose specialty is relevant to the injury for
31 which the evaluation is sought as identified by the report of the
32 treating physician. The medical director shall advise the employee
33 that he or she should consult with his or her treating physician prior
34 to deciding which type of specialist to request.

35 (2) The administrative director shall prescribe a form that shall
36 notify the employee of the physicians selected for his or her panel.
37 The form shall include, for each physician on the panel, the
38 physician's name, address, telephone number, specialty, number
39 of years in practice, and a brief description of his or her education
40 and training, and shall advise the employee that he or she is entitled



1 to receive transportation expenses and temporary disability for
2 each day necessary for the examination. The form shall also state
3 in a clear and conspicuous location and type: “You have the right
4 to consult with an information and assistance officer at no cost to
5 you prior to selecting the doctor to prepare your evaluation, or you
6 may consult with an attorney. If your claim eventually goes to
7 court, the judge will consider the evaluation prepared by the doctor
8 you select to decide your claim.”

9 (3) When compiling the list of evaluators from which to select
10 randomly, the medical director shall include all qualified medical
11 evaluators who meet all of the following criteria:

12 (A) He or she does not have a conflict of interest in the case, as
13 defined by regulations adopted pursuant to subdivision (o).

14 (B) He or she is certified by the administrative director to
15 evaluate in an appropriate specialty and at locations within the
16 general geographic area of the employee’s residence.

17 (C) He or she has not been suspended or terminated as a
18 qualified medical evaluator for failure to pay the fee required by
19 the administrative director pursuant to subdivision (n) or for any
20 other reason.

21 (4) When the medical director determines that an employee has
22 requested an evaluation by a type of specialist that is appropriate
23 for the employee’s injury, but there are not enough qualified
24 medical evaluators of that type within the general geographic area
25 of the employee’s residence to establish a three-member panel, the
26 medical director shall include sufficient qualified medical
27 evaluators from other geographic areas and the employer shall pay
28 all necessary travel costs incurred in the event the employee selects
29 an evaluator from another geographic area.

30 (i) The medical director appointed pursuant to Section 3122,
31 shall continuously review the quality of comprehensive medical
32 evaluations and reports prepared by agreed and qualified medical
33 evaluators and the timeliness with which evaluation reports are
34 prepared and submitted. The review shall include, but not be
35 limited to, a review of a random sample of reports submitted to the
36 division, and a review of all reports alleged to be inaccurate or
37 incomplete by a party to a case for which the evaluation was
38 prepared. The medical director shall submit to the administrative
39 director an annual report summarizing the results of the
40 continuous review of medical evaluations and reports prepared by



1 agreed and qualified medical evaluators and make
2 recommendations for the improvement of the system of medical
3 evaluations and determinations.

4 (j) After public hearing pursuant to Section 5307.4, the
5 administrative director shall adopt regulations concerning the
6 following medical issues:

7 (1) Standards governing the timeframes within which medical
8 evaluations shall be prepared and submitted by agreed and
9 qualified medical evaluators. Except as provided in this
10 subdivision, the timeframe for initial medical evaluations to be
11 prepared and submitted shall be no more than 30 days after the
12 evaluator has seen the employee or otherwise commenced the
13 medical evaluation procedure. The administrative director shall
14 develop timeframes governing availability of qualified medical
15 evaluators for unrepresented employees under Sections 4061 and
16 4062. These timeframes shall give the employee the right to the
17 addition of a new evaluator to his or her panel, selected at random,
18 for each evaluator not available to see the employee within a
19 specified period of time, but shall also permit the employee to
20 waive this right for a specified period of time thereafter. The
21 administrative director shall adopt regulations governing the
22 provision of extensions of the 30-day period in both of the
23 following cases:

24 (A) Where the evaluator has not received test results or
25 consulting physician's evaluations in time to meet the 30-day
26 deadline.

27 (B) To extend the 30-day period by not more than 15 days when
28 the failure to meet the 30-day deadline was for good cause. For
29 purposes of this subdivision, "good cause" means any of the
30 following:

31 (i) Medical emergencies of the evaluator or evaluator's family.

32 (ii) Death in the evaluator's family.

33 (iii) Natural disasters or other community catastrophes that
34 interrupt the operation of the evaluator's business.

35 (2) Procedures to be followed by all physicians in evaluating
36 the existence and extent of permanent impairment and limitations
37 resulting from an injury. In order to produce complete, accurate,
38 uniform, and replicable evaluations, the procedures shall require
39 that an evaluation of anatomical loss, functional loss, and the
40 presence of physical complaints be supported, to the extent



1 feasible, by objective findings and based on standardized
2 examinations and testing techniques generally accepted by the
3 medical community. Objective findings in support of medical
4 evidence are verifiable indications of injury or disease that may
5 include, but are not limited to, range of motion, atrophy, muscle
6 strength, and palpable muscle spasm. Objective findings do not
7 include physical findings or subjective responses to physical
8 examinations that are not reproducible, measurable, or observable.

9 (3) Procedures governing the determination of any disputed
10 medical issues.

11 (4) Procedures to be used in determining the compensability of
12 psychiatric injury. The procedures shall be in accordance with
13 Section 3208.3 and shall require that the diagnosis of a mental
14 disorder be expressed using the terminology and criteria of the
15 American Psychiatric Association's Diagnostic and Statistical
16 Manual of Mental Disorders, Third Edition-Revised, or the
17 terminology and diagnostic criteria of other psychiatric diagnostic
18 manuals generally approved and accepted nationally by
19 practitioners in the field of psychiatric medicine.

20 (5) Guidelines for the range of time normally required to
21 perform the following:

22 (A) A medical-legal evaluation that has not been defined and
23 valued pursuant to Section 5307.6. However, the administrative
24 director may recommend guidelines for evaluations that have been
25 defined and valued pursuant to Section 5307.6 for the purpose of
26 governing the appointment, reappointment, and discipline of
27 qualified medical evaluators. The guidelines shall establish
28 minimum times for patient contact in the conduct of the
29 evaluations, and shall be consistent with regulations adopted
30 pursuant to Section 5307.6.

31 (B) Any treatment procedures that have not been defined and
32 valued pursuant to Section 5307.1.

33 (C) Any other evaluation procedure requested by the Insurance
34 Commissioner or deemed appropriate by the administrative
35 director.

36 (6) Any additional medical or professional standards that a
37 medical evaluator shall meet as a condition of appointment,
38 reappointment, or maintenance in the status of a medical evaluator.

39 (k) (1) Except as provided in this subdivision, the
40 administrative director may, in his or her discretion, suspend or



1 terminate the privilege of a physician to serve as a qualified
2 medical evaluator if the administrative director, after hearing
3 pursuant to subdivision (l), determines, based on substantial
4 evidence, that a qualified medical evaluator:

5 (A) Has violated any material statutory or administrative duty.

6 (B) Has failed to follow the medical procedures or
7 qualifications established by the administrative director pursuant
8 to paragraph (2), (3), (4), or (5) of subdivision (j).

9 (C) Has failed to comply with the timeframe standards
10 established by the administrative director pursuant to subdivision
11 (j).

12 (D) Has failed to meet the requirements of subdivision (b) or
13 (c).

14 (E) Has prepared medical-legal evaluations that fail to meet the
15 minimum standards for those reports established by the
16 administrative director or the appeals board.

17 (F) Has made material misrepresentations or false statements
18 in an application for appointment or reappointment as a qualified
19 medical evaluator.

20 (2) No hearing shall be required prior to the suspension or
21 termination of a physician's privilege to serve as a qualified
22 medical evaluator when the physician has done either of the
23 following:

24 (A) Failed to timely pay the fee required pursuant to
25 subdivision (n).

26 (B) Had his or her license to practice in California suspended
27 by the relevant licensing authority so as to preclude practice, or had
28 the license revoked or terminated by the licensing authority.

29 (l) The administrative director shall cite the qualified medical
30 evaluator for a violation listed in subdivision (k) and shall set a
31 hearing on the alleged violation within 30 days of service of the
32 citation on the qualified medical evaluator. In addition to the
33 authority to terminate or suspend the qualified medical evaluator
34 upon finding a violation listed in subdivision (k), the
35 administrative director may, in his or her discretion, place a
36 qualified medical evaluator on probation subject to appropriate
37 conditions, including ordering continuing education or training.
38 The administrative director shall report to the appropriate
39 licensing board the name of any qualified medical evaluator who
40 is disciplined pursuant to this subdivision.



1 (m) The administrative director shall terminate from the list of
2 medical evaluators any physician where licensure has been
3 terminated by the relevant licensing board, or who has been
4 convicted of a misdemeanor or felony related to the conduct of his
5 or her medical practice, or of a crime of moral turpitude. The
6 administrative director shall suspend or terminate as a medical
7 evaluator any physician who has been suspended or placed on
8 probation by the relevant licensing board. If a physician is
9 suspended or terminated as a qualified medical evaluator under
10 this subdivision, a report prepared by the physician that is not
11 complete, signed, and furnished to one or more of the parties prior
12 to the date of conviction or action of the licensing board,
13 whichever is earlier, shall not be admissible in any proceeding
14 before the appeals board nor shall there be any liability for
15 payment for the report and any expense incurred by the physician
16 in connection with the report.

17 (n) Each qualified medical evaluator shall pay a fee, as
18 determined by the administrative director, for appointment or
19 reappointment. Any qualified medical evaluator appointed prior
20 to January 1, 1993, shall also pay the same fee as specified in
21 accordance with this subdivision. These fees shall be based on a
22 sliding scale as established by the administrative director. All
23 revenues from fees paid under this subdivision shall be deposited
24 into the Workers' Compensation Administration Revolving Fund
25 and are available for expenditure upon appropriation by the
26 Legislature for the administration of the programs of the Division
27 of Workers' Compensation related to the provision of medical
28 treatment to injured employees.

29 (o) An evaluator may not request or accept any compensation
30 or other thing of value from any source that does or could create
31 a conflict with his or her duties as an evaluator under this code. The
32 administrative director, after consultation with the Commission on
33 Health and Safety and Workers' Compensation, shall adopt
34 regulations to implement this subdivision.

35 3139.3. (a) Notwithstanding any other provision of law, to
36 the extent those services are paid pursuant to this division, it is
37 unlawful for a physician to refer a person for clinical laboratory,
38 diagnostic nuclear medicine, radiation oncology, physical therapy,
39 physical rehabilitation, psychometric testing, home infusion
40 therapy, or diagnostic imaging goods or services whether for



1 treatment or medical-legal purposes if the physician or his or her
2 immediate family has a financial interest with the person or in the
3 entity that receives the referral.

4 (b) For purposes of this section and Section 3139.31, the
5 following shall apply:

6 (1) “Diagnostic imaging” includes, but is not limited to, all
7 X-ray, computed axial tomography magnetic resonance imaging,
8 nuclear medicine, positron emission tomography, mammography,
9 and ultrasound goods and services.

10 (2) “Immediate family” includes the spouse and children of
11 the physician, the parents of the physician, and the spouses of the
12 children of the physician.

13 (3) “Physician” means a physician as defined in Section
14 3209.3.

15 (4) A “financial interest” includes, but is not limited to, any
16 type of ownership, interest, debt, loan, lease, compensation,
17 remuneration, discount, rebate, refund, dividend, distribution,
18 subsidy, or other form of direct or indirect payment, whether in
19 money or otherwise, between a licensee and a person or entity to
20 whom the physician refers a person for a good or service specified
21 in subdivision (a). A financial interest also exists if there is an
22 indirect relationship between a physician and the referral
23 recipient, including, but not limited to, an arrangement whereby
24 a physician has an ownership interest in any entity that leases
25 property to the referral recipient. Any financial interest transferred
26 by a physician to, or otherwise established in, any person or entity
27 for the purpose of avoiding the prohibition of this section shall be
28 deemed a financial interest of the physician.

29 (5) A “physician’s office” is either of the following:

30 (A) An office of a physician in solo practice.

31 (B) An office in which the services or goods are personally
32 provided by the physician or by employees in that office, or
33 personally by independent contractors in that office, in accordance
34 with other provisions of law. Employees and independent
35 contractors shall be licensed or certified when that licensure or
36 certification is required by law.

37 (6) The “office of a group practice” is an office or offices in
38 which two or more physicians are legally organized as a
39 partnership, professional corporation, or not-for-profit
40 corporation licensed according to subdivision (a) of Section 1204



1 of the Health and Safety Code for which all of the following are
2 applicable:

3 (A) Each physician who is a member of the group provides
4 substantially the full range of services that the physician routinely
5 provides, including medical care, consultation, diagnosis, or
6 treatment, through the joint use of shared office space, facilities,
7 equipment, and personnel.

8 (B) Substantially all of the services of the physicians who are
9 members of the group are provided through the group and are
10 billed in the name of the group and amounts so received are treated
11 as receipts of the group, and except that in the case of
12 multispecialty clinics, as defined in subdivision (l) of Section 1206
13 of the Health and Safety Code, physician services are billed in the
14 name of the multispecialty clinic and amounts so received are
15 treated as receipts of the multispecialty clinic.

16 (C) The overhead expenses of, and the income from, the
17 practice are distributed in accordance with methods previously
18 determined by members of the group.

19 (c) (1) It is unlawful for a licensee to enter into an arrangement
20 or scheme, such as a cross-referral arrangement, that the licensee
21 knows, or should know, has a principal purpose of ensuring
22 referrals by the licensee to a particular entity that, if the licensee
23 directly made referrals to that entity, would be in violation of this
24 section.

25 (2) It shall be unlawful for a physician to offer, deliver, receive,
26 or accept any rebate, refund, commission, preference, patronage
27 dividend, discount, or other consideration, whether in the form of
28 money or otherwise, as compensation or inducement for a referred
29 evaluation or consultation.

30 (d) No claim for payment shall be presented by an entity to any
31 individual, third-party payor, or other entity for a good or service
32 furnished pursuant to a referral prohibited under this section.

33 (e) A physician who refers to or seeks consultation from an
34 organization in which the physician has a financial interest shall
35 disclose this interest to the patient or if the patient is a minor, to the
36 patient’s parents or legal guardian in writing at the time of the
37 referral.

38 (f) No insurer, self-insurer, or other payor shall pay a charge or
39 lien for any good or service resulting from a referral in violation
40 of this section.



1 (g) A violation of subdivision (a) is a misdemeanor. The
2 appropriate licensing board shall review the facts and
3 circumstances of any conviction pursuant to subdivision (a) and
4 take appropriate disciplinary action if the licensee has committed
5 unprofessional conduct. Violations of this section may also be
6 subject to civil penalties of up to five thousand dollars (\$5,000) for
7 each offense, which may be enforced by the Insurance
8 Commissioner, Attorney General, or a district attorney. A
9 violation of subdivision (c), (d), (e), or (f) is a public offense and
10 is punishable upon conviction by a fine not exceeding fifteen
11 thousand dollars (\$15,000) for each violation and appropriate
12 disciplinary action, including revocation of professional licensure,
13 by the Medical Board of California or other appropriate
14 governmental agency.

15 3139.31. The prohibition of Section 3139.3 shall not apply to
16 or restrict any of the following:

17 (a) A physician may refer a patient for a good or service
18 otherwise prohibited by subdivision (a) of Section 3139.3 if the
19 physician's regular practice is where there is no alternative
20 provider of the service within either 25 miles or 40 minutes
21 traveling time, via the shortest route on a paved road. A physician
22 who refers to, or seeks consultation from, an organization in which
23 the physician has a financial interest under this subdivision shall
24 disclose this interest to the patient or the patient's parents or legal
25 guardian in writing at the time of referral.

26 (b) A physician who has one or more of the following
27 arrangements with another physician, a person, or an entity, is not
28 prohibited from referring a patient to the physician, person, or
29 entity because of the arrangement:

30 (1) A loan between a physician and the recipient of the referral,
31 if the loan has commercially reasonable terms, bears interest at the
32 prime rate or a higher rate that does not constitute usury, is
33 adequately secured, and the loan terms are not affected by either
34 party's referral of any person or the volume of services provided
35 by either party.

36 (2) A lease of space or equipment between a physician and the
37 recipient of the referral, if the lease is written, has commercially
38 reasonable terms, has a fixed periodic rent payment, has a term of
39 one year or more, and the lease payments are not affected by either



1 party's referral of any person or the volume of services provided
2 by either party.

3 (3) A physician's ownership of corporate investment
4 securities, including shares, bonds, or other debt instruments that
5 were purchased on terms that are available to the general public
6 through a licensed securities exchange or NASDAQ, do not base
7 profit distributions or other transfers of value on the physician's
8 referral of persons to the corporation, do not have a separate class
9 or accounting for any persons or for any physicians who may refer
10 persons to the corporation, and are in a corporation that had, at the
11 end of the corporation's most recent fiscal year, total gross assets
12 exceeding one hundred million dollars (\$100,000,000).

13 (4) A personal services arrangement between a physician or an
14 immediate family member of the physician and the recipient of the
15 referral if the arrangement meets all of the following requirements:

16 (A) It is set out in writing and is signed by the parties.

17 (B) It specifies all of the services to be provided by the
18 physician or an immediate family member of the physician.

19 (C) The aggregate services contracted for do not exceed those
20 that are reasonable and necessary for the legitimate business
21 purposes of the arrangement.

22 (D) A written notice disclosing the existence of the personal
23 services arrangement and including information on where a person
24 may go to file a complaint against the licensee or the immediate
25 family member of the licensee, is provided to the following
26 persons at the time any services pursuant to the arrangement are
27 first provided:

28 (i) An injured worker who is referred by a licensee or an
29 immediate family member of the licensee.

30 (ii) The injured worker's employer, if self-insured.

31 (iii) The injured worker's employer's insurer, if insured.

32 (iv) If the injured worker is known by the licensee or the
33 recipient of the referral to be represented, the injured worker's
34 attorney.

35 (E) The term of the arrangement is for at least one year.

36 (F) The compensation to be paid over the term of the
37 arrangement is set in advance, does not exceed fair market value,
38 and is not determined in a manner that takes into account the
39 volume or value of any referrals or other business generated
40 between the parties, except that if the services provided pursuant



1 to the arrangement include medical services provided under this
2 division, compensation paid for the services shall be subject to the
3 official medical fee schedule promulgated pursuant to Section
4 5307.1 or subject to any contract authorized by Section 5307.11.

5 (G) The services to be performed under the arrangement do not
6 involve the counseling or promotion of a business arrangement or
7 other activity that violates any state or federal law.

8 (c) (1) A physician may refer a person to a health facility as
9 defined in Section 1250 of the Health and Safety Code, or to any
10 facility owned or leased by a health facility, if the recipient of the
11 referral does not compensate the physician for the patient referral,
12 and any equipment lease arrangement between the physician and
13 the referral recipient complies with the requirements of paragraph
14 (2) of subdivision (b).

15 (2) Nothing shall preclude this subdivision from applying to a
16 physician solely because the physician has an ownership or
17 leasehold interest in an entire health facility or an entity that owns
18 or leases an entire health facility.

19 (3) A physician may refer a person to a health facility for any
20 service classified as an emergency under subdivision (a) or (b) of
21 Section 1317.1 of the Health and Safety Code. For nonemergency
22 outpatient diagnostic imaging services performed with equipment
23 for that, when new, has a commercial retail price of four hundred
24 thousand dollars (\$400,000) or more, the referring physician shall
25 obtain a service preauthorization from the insurer, or self-insured
26 employer. Any oral authorization shall be memorialized in writing
27 within five business days.

28 (d) A physician compensated or employed by a university may
29 refer a person to any facility owned or operated by the university,
30 or for a physician service, to another physician employed by the
31 university, provided that the facility or university does not
32 compensate the referring physician for the patient referral. For
33 nonemergency diagnostic imaging services performed with
34 equipment that, when new, has a commercial retail price of four
35 hundred thousand dollars (\$400,000) or more, the referring
36 physician shall obtain a service preauthorization from the insurer
37 or self-insured employer. An oral authorization shall be
38 memorialized in writing within five business days. In the case of
39 a facility that is totally or partially owned by an entity other than
40 the university, but that is staffed by university physicians, those



1 physicians may not refer patients to the facility if the facility
2 compensates the referring physician for those referrals.

3 (e) The prohibition of Section 3139.3 shall not apply to any
4 service for a specific patient that is performed within, or goods that
5 are supplied by, a physician's office, or the office of a group
6 practice. Further, the provisions of Section 3139.3 shall not alter,
7 limit, or expand a physician's ability to deliver, or to direct or
8 supervise the delivery of, in-office goods or services according to
9 the laws, rules, and regulations governing his or her scope of
10 practice. With respect to diagnostic imaging services performed
11 with equipment that, when new, had a commercial retail price of
12 four hundred thousand dollars (\$400,000) or more, or for physical
13 therapy services, or for psychometric testing that exceeds the
14 routine screening battery protocols, with a time limit of two to five
15 hours, established by the administrative director, the referring
16 physician shall obtain a service preauthorization from the insurer
17 or self-insured employer. Any oral authorization shall be
18 memorialized in writing within five business days.

19 (f) The prohibition of Section 3139.3 shall not apply where the
20 physician is in a group practice as defined in Section 3139.3 and
21 refers a person for services specified in Section 3139.3 to a
22 multispecialty clinic, as defined in subdivision (I) of Section 1206
23 of the Health and Safety Code. For diagnostic imaging services
24 performed with equipment that, when new, had a commercial
25 retail price of four hundred thousand dollars (\$400,000) or more,
26 or physical therapy services, or psychometric testing that exceeds
27 the routine screening battery protocols, with a time limit of two to
28 five hours, established by the administrative director, performed
29 at the multispecialty facility, the referring physician shall obtain
30 a service preauthorization from the insurer or self-insured
31 employer. Any oral authorization shall be memorialized in writing
32 within five business days.

33 (g) The requirement for preauthorization in Sections (c), (e),
34 and (f) shall not apply to a patient for whom the physician or group
35 accepts payment on a capitated risk basis.

36 (h) The prohibition of Section 3139.3 shall not apply to any
37 facility when used to provide health care services to an enrollee of
38 a health care service plan licensed pursuant to the Knox-Keene
39 Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing
40 with Section 1340) of Division 2 of the Health and Safety Code).



1 3139.4. (a) The administrative director may review
2 advertising copy to ensure compliance with Section 651 of the
3 Business and Professions Code and may require qualified medical
4 evaluators to maintain a file of all advertising copy for a period of
5 90 days from the date of its use. Any file so required to be
6 maintained shall be available to the administrative director upon
7 his or her request for review.

8 (b) No advertising copy shall be used after its use has been
9 disapproved by the administrative director and the qualified
10 medical evaluator has been notified in writing of the disapproval.

11 (c) A qualified medical evaluator who is found by the
12 administrative director to have violated any provision of this
13 section may be terminated, suspended, or placed on probation by
14 the administrative director.

15 (d) Proceedings to determine whether a violation of this section
16 has occurred shall be conducted pursuant to Chapter 4
17 (commencing with Section 11370) of Part 1 of Division 3 of Title
18 2 of the Government Code.

19 (e) The administrative director shall adopt regulations
20 governing advertising by physicians with respect to industrial
21 injuries or illnesses. In adopting regulations pursuant to this
22 subdivision, the administrative director shall review existing
23 regulations, including regulations adopted by the State Bar, to
24 identify those existing regulatory approaches that may serve as a
25 model for regulations required by this subdivision.

26 (f) Subdivision (a) shall not be construed to alter the
27 application of Section 651 of the Business and Professions Code.

28 3139.43. (a) No person or entity shall advertise, print,
29 display, publish, distribute, or broadcast, or cause or permit to be
30 advertised, printed, displayed, published, distributed, or broadcast
31 in any manner, any statement concerning services or benefits to be
32 provided to an injured worker, that is paid for directly or indirectly
33 by that person or entity and is false, misleading, or deceptive, or
34 that omits material information necessary to make the statement
35 therein not false, misleading, or deceptive.

36 (b) The administrative director shall adopt regulations
37 governing advertising by persons or entities other than physicians
38 and attorneys with respect to services or benefits for injured
39 workers. In promulgating regulations pursuant to this subdivision,
40 the administrative director shall review existing regulations,



1 including those adopted by the State Bar, to identify those
2 regulatory approaches that may serve as a model for regulations
3 required by this subdivision.

4 (c) A violation of subdivision (a) is a misdemeanor, punishable
5 by incarceration in a county jail for not more than one year, or by
6 a fine not exceeding ten thousand dollars (\$10,000), or both.

7 (d) This section shall not apply to physicians or attorneys. It is
8 the intent of the Legislature to exempt physicians and attorneys
9 from this section because the conduct regulated by this section,
10 with respect to physicians and attorneys, is governed by other
11 provisions of law.

12 3139.45. (a) In adopting regulations pursuant to Sections
13 3139.4 and 3139.43, the administrative director shall take
14 particular care to preclude any advertisements with respect to
15 industrial injuries or illnesses that are false or mislead the public
16 with respect to workers' compensation. In adopting rules with
17 respect to advertising, the State Bar and physician licensing boards
18 shall also take particular care to achieve the same goal.

19 (b) For purposes of subdivision (a), false or misleading
20 advertisements shall include advertisements that do any of the
21 following:

- 22 (1) Contain an untrue statement.
- 23 (2) Contain any matter, or present or arrange any matter in a
24 manner or format that is false, deceptive, or that tends to confuse,
25 deceive, or mislead.
- 26 (3) Omit any fact necessary to make the statement made, in the
27 light of the circumstances under which the statement is made, not
28 misleading.
- 29 (4) Are transmitted in any manner that involves coercion,
30 duress, compulsion, intimidation, threats, or vexatious or
31 harassing conduct.
- 32 (5) Entice a person to respond by the offering of any
33 consideration, including a good or service but excluding free
34 medical evaluations or treatment, that would be provided either at
35 no charge or for less than market value. No free medical evaluation
36 or treatment shall be offered for the purpose of defrauding any
37 entity.

38 3139.47. The Director of Industrial Relations shall establish
39 and maintain a program to encourage, facilitate, and educate
40 employers to provide early and sustained return to work after



1 occupational injury or illness. The program shall do both of the
2 following:

3 (a) Develop educational materials and guides, in easily
4 understandable language in both print and electronic form, for
5 employers, health care providers, employees, and labor unions.
6 These materials shall address issues including, but not limited to,
7 early return to work, assessment of functional abilities and
8 limitations, development of appropriate work restrictions, job
9 analysis, worksite modifications, assistive equipment and devices,
10 and available resources.

11 (b) Conduct training for employee and employer organizations
12 and health care providers concerning the accommodation of
13 injured employees and the prevention of reinjury.

14 3139.48. (a) The administrative director shall establish the
15 Return-to-Work Program in order to promote the early and
16 sustained return to work of the employee following a work-related
17 injury or illness.

18 (b) Upon submission by employers of documentation in
19 accordance with regulations adopted pursuant to subdivision (h),
20 the administrative director shall pay the wage reimbursement,
21 workplace modification expense reimbursement, and premium
22 reimbursement allowed under this section.

23 (c) Any employer, except the state or an employer eligible to
24 secure the payment of compensation pursuant to subdivision (c) of
25 Section 3700, may apply for a reimbursement for wages paid to an
26 employee who has returned to modified or alternative work, as
27 defined in paragraphs (5) and (6) of subdivision (a) of Section
28 4644, with the employer during the period the employee is
29 temporarily disabled from his or her employment in accordance
30 with all of the following:

31 (1) The reimbursement shall be allowed for up to 50 percent of
32 wages paid to the employee.

33 (2) The reimbursement shall be allowed for a period of no more
34 than 90 days, or until the employee is released to the full duties of
35 his or her usual occupation, or until the employee's condition
36 becomes permanent and stationary, whichever occurs first.

37 (3) The modified or alternative work is compatible with the
38 employee's documented work restrictions imposed by the treating
39 physician as a result of the work injury or illness.



1 (4) The reimbursement shall be paid from the Workers'
2 Compensation Return-to-Work Fund, created in subdivision (i), as
3 a reimbursement to the employer after submission of
4 documentation of eligibility and wages paid.

5 (d) The administrative director shall reimburse an employer for
6 expenses incurred to make workplace modifications to
7 accommodate the employee's return to modified or alternative
8 work, as follows:

9 (1) The maximum reimbursement to an employer for expenses
10 to accommodate each temporarily disabled injured worker is one
11 thousand two hundred fifty dollars (\$1,250).

12 (2) The maximum reimbursement to an employer for expenses
13 to accommodate each permanently disabled worker who is a
14 qualified injured worker is two thousand five hundred dollars
15 (\$2,500). If the employer received reimbursement under
16 paragraph (1), the amount of the reimbursement under paragraph
17 (1) and this paragraph shall not exceed two thousand five hundred
18 dollars (\$2,500).

19 (3) The modification expenses shall be incurred in order to
20 allow a temporarily disabled worker to perform modified or
21 alternative work within physician-imposed temporary work
22 restrictions, or to allow a permanently disabled worker who is a
23 qualified injured worker to return to sustained modified or
24 alternative employment with the employer within
25 physician-imposed permanent work restrictions.

26 (4) Allowable expenses may include physical modifications to
27 the worksite, equipment, devices, furniture, tools, or other
28 necessary costs for accommodation of the employee's restrictions.

29 (e) (1) An insured employer may apply to the administrative
30 director for reimbursement of workers' compensation insurance
31 premiums attributable to the sustained employment of a qualified
32 injured worker following the period for premium refund provided
33 in subdivision (a) of Section 4638. The reimbursement shall be
34 equal to the standard premium computed on the wages paid by the
35 employer to the qualified injured worker during each 12-month
36 period.

37 (2) An employer that employs 100 or fewer employees on the
38 date of injury may be reimbursed for 100 percent of the workers'
39 compensation insurance premium paid for the employee for up to
40 two years. An employer that employs more than 100 employees on



1 the date of injury may be reimbursed for 50 percent of the workers’
2 compensation insurance premium paid for the employee for up to
3 two years. The period subject to premium reimbursement shall
4 begin on the first day after the end of the 12-month period for
5 premium refund provided in subdivision (a) of Section 4638 and
6 shall continue for a maximum of two years.

7 (3) The premium reimbursement shall be paid to the employer
8 annually after each consecutive period of 12 months, provided that
9 the qualified injured worker continues modified or alternative
10 employment with that employer in a regular position that pays at
11 least 85 percent of the employee’s pre-injury wages and
12 compensation.

13 (f) This section shall not create a preference in employment for
14 injured employees over noninjured employees. It shall be
15 unlawful for an employer to discriminatorily terminate, lay off,
16 demote, or otherwise displace an employee in order to return an
17 industrially injured employee to employment for the purpose of
18 obtaining the reimbursement set forth in subdivisions (c), (d), or
19 (e).

20 (g) For purposes of this section, “employee” means a worker
21 who has suffered a work-related injury or illness on or after July
22 1, 2004.

23 (h) The administrative director shall adopt regulations to carry
24 out this section. Regulations allocating budget funds that are
25 insufficient to implement the maximum wage reimbursement,
26 workplace modification expense reimbursement, and premium
27 reimbursement provided for in this section shall include a
28 prioritization schema according to which employers with less than
29 100 employees shall be given preference in the allocation of those
30 funds.

31 (i) The Workers’ Compensation Return-to-Work Fund is
32 hereby created as a special fund in the State Treasury. The fund
33 shall be administered by the administrative director. Moneys in the
34 fund may be expended by the administrative director, upon
35 appropriation by the Legislature, only for purposes of
36 implementing this section. The unencumbered balance remaining
37 in the fund as of January 1, 2009, shall revert to the General Fund.

38 (j) This section shall be operative on July 1, 2004.

39 (k) This section shall not be implemented unless and until funds
40 are appropriated by the Legislature for this purpose in the annual



1 Budget Act or other statute commencing with the 2004–05 fiscal
2 year.

3 (I) This section shall remain in effect only until January 1,
4 2009, and as of that date is repealed, unless a later enacted statute,
5 that is enacted before January 1, 2009, deletes or extends that date.

6 3139.49. (a) The administrative director shall contract with
7 an independent research organization to conduct a study and issue
8 a report on the Return-to-Work Program established in Section
9 3139.48. The study shall examine at least two years’ operation of
10 the program and shall address all of the following:

11 (1) The effectiveness of the wage reimbursement, workplace
12 modification expense reimbursement, and premium
13 reimbursement components of the program.

14 (2) The rate of participation by insured and self-insured
15 employers, including information on the size and industry of
16 employers.

17 (3) Comparison of rates of utilization of modified and
18 alternative work before and after establishment of the program and
19 evaluation of whether there is an increase in sustained return to
20 work.

21 (4) The impact of the program on injured employees.

22 (5) The cost-effectiveness of the program.

23 (6) Identification of potential future funding mechanisms for
24 the program.

25 (b) On or before January 1, 2008, the administrative director
26 shall make the report available to the public and the Legislature.

27 (c) This section shall remain in effect only until January 1,
28 2009, and as of that date is repealed, unless a later enacted statute,
29 that is enacted before January 1, 2009, deletes or extends that date.

30 3139.5. (a) The administrative director shall establish a
31 vocational rehabilitation unit that shall include appropriate
32 professional staff and have the following duties:

33 (1) To foster, review, and approve vocational rehabilitation
34 plans developed by a qualified rehabilitation representative of the
35 employer, insurer, state agency, or employee. Plans agreed to by
36 the employer and employee do not require approval by the
37 vocational rehabilitation unit unless the employee is
38 unrepresented.

39 (2) To develop rules and regulations, to be adopted by the
40 administrative director, providing for a procedure in which an



1 employee may waive the services of a qualified rehabilitation
2 representative where the employee has been enrolled and made
3 substantial progress toward completion of a degree or certificate
4 from a community college, California State University, or the
5 University of California and desires a plan to complete the degree
6 or certificate. These rules and regulations shall provide that this
7 waiver as well as any plan developed without the assistance of a
8 qualified rehabilitation representative must be approved by the
9 rehabilitation unit.

10 (3) To develop rules and regulations, to be adopted by the
11 administrative director, which would expedite and facilitate the
12 identification, notification and referral of industrially injured
13 employees to vocational rehabilitation services.

14 (4) To coordinate and enforce the implementation of vocational
15 rehabilitation plans.

16 (5) To develop a fee schedule, to be adopted by the
17 administrative director, governing reasonable fees for vocational
18 rehabilitation services provided on and after January 1, 1991. The
19 initial fee schedule promulgated under this paragraph shall be
20 designed to reduce the cost of vocational rehabilitation services by
21 10 percent from the level of fees paid during 1989. On or before
22 July 1, 1994, the administrative director shall establish the
23 maximum aggregate permissible fees that may be charged for
24 counseling. Those fees shall not exceed four thousand five
25 hundred dollars (\$4,500) and shall be included within the sixteen
26 thousand dollar (\$16,000) cap. The fee schedule shall permit up to
27 (A) three thousand dollars (\$3,000) for vocational evaluation,
28 evaluation of vocational feasibility, initial interview, vocational
29 testing, counseling and research for plan development, and
30 preparation of the Division of Workers' Compensation Form 102,
31 and (B) three thousand five hundred dollars (\$3,500) for plan
32 monitoring, job seeking skills, and job placement research and
33 counseling. However, in no event shall the aggregate of (A) and
34 (B) exceed four thousand five hundred dollars (\$4,500).

35 (6) To develop standards, to be adopted by the administrative
36 director, for governing the timeliness and the quality of vocational
37 rehabilitation services.

38 (b) The salaries of the personnel of the vocational rehabilitation
39 unit shall be fixed by the Department of Personnel Administration.



1 (c) When an employee is determined to be medically eligible
2 and chooses to participate in a vocational rehabilitation program,
3 he or she shall continue to receive temporary disability indemnity
4 payments only until his or her medical condition becomes
5 permanent and stationary and, thereafter, may receive a
6 maintenance allowance. Rehabilitation maintenance allowance
7 payments shall begin after the employee's medical condition
8 becomes permanent and stationary, upon a request for vocational
9 rehabilitation services. Thereafter, the maintenance allowance
10 shall be paid for a period not to exceed 52 weeks in the aggregate,
11 except where the overall cap on vocational rehabilitation services
12 can be exceeded under this section or Section 4642 or subdivision
13 (d) or (e) of Section 4644.

14 The employee also shall receive additional living expenses
15 necessitated by the vocational rehabilitation services, together
16 with all reasonable and necessary vocational training, at the
17 expense of the employer, but in no event shall the expenses,
18 counseling fees, training, maintenance allowance, and costs
19 associated with, or arising out of, vocational rehabilitation
20 services incurred after the employee's request for vocational
21 rehabilitation services, except temporary disability payments,
22 exceed sixteen thousand dollars (\$16,000). The administrative
23 director shall adopt regulations to ensure that the continued receipt
24 of vocational rehabilitation maintenance allowance benefits is
25 dependent upon the injured worker's regular and consistent
26 attendance at, and participation in, his or her vocational
27 rehabilitation program.

28 (d) The amount of the maintenance allowance due under
29 subdivision (c) shall be two-thirds of the employee's average
30 weekly earnings at the date of injury payable as follows:

31 (1) The amount the employee would have received as
32 continuing temporary disability indemnity, but not more than two
33 hundred forty-six dollars (\$246) a week for injuries occurring on
34 or after January 1, 1990.

35 (2) At the employee's option, an additional amount from
36 permanent disability indemnity due or payable, sufficient to
37 provide the employee with a maintenance allowance equal to
38 two-thirds of the employee's average weekly earnings at the date
39 of injury subject to the limits specified in subdivision (a) of Section
40 4453 and the requirements of Section 4661.5. In no event shall



1 temporary disability indemnity and maintenance allowance be
2 payable concurrently.

3 If the employer disputes the treating physician's determination
4 of medical eligibility, the employee shall continue to receive that
5 portion of the maintenance allowance payable under paragraph (1)
6 pending final determination of the dispute. If the employee
7 disputes the treating physician's determination of medical
8 eligibility and prevails, the employee shall be entitled to that
9 portion of the maintenance allowance payable under paragraph (1)
10 retroactive to the date of the employee's request for vocational
11 rehabilitation services. These payments shall not be counted
12 against the maximum expenditures for vocational rehabilitation
13 services provided by this section.

14 (e) No provision of this section nor of any rule, regulation, or
15 vocational rehabilitation plan developed or adopted under this
16 section nor any benefit provided pursuant to this section shall
17 apply to an injured employee whose injury occurred prior to
18 January 1, 1975. Nothing in this section shall affect any plan,
19 benefit, or program authorized by this section as added by Chapter
20 1513 of the Statutes of 1965 or as amended by Chapter 83 of the
21 Statutes of 1972.

22 (f) The time within which an employee may request vocational
23 rehabilitation services is set forth in Sections 5405.5, 5410, and
24 5803.

25 (g) An offer of a job within state service to a state employee in
26 State Bargaining Unit 1, 4, 15, 18, or 20 at the same or similar
27 salary and the same or similar geographic location is a prima facie
28 offer of vocational rehabilitation under this statute.

29 (h) It shall be unlawful for a qualified rehabilitation
30 representative or rehabilitation counselor to refer any employee to
31 any work evaluation facility or to any education or training
32 program if the qualified rehabilitation representative or
33 rehabilitation counselor, or a spouse, employer, coemployee, or
34 any party with whom he or she has entered into contract, express
35 or implied, has any proprietary interest in or contractual
36 relationship with the work evaluation facility or education or
37 training program. It shall also be unlawful for any insurer to refer
38 any injured worker to any rehabilitation provider or facility if the
39 insurer has a proprietary interest in the rehabilitation provider or
40 facility or for any insurer to charge against any claim for the



1 expenses of employees of the insurer to provide vocational
2 rehabilitation services unless those expenses are disclosed to the
3 insured and agreed to in advance.

4 (i) Any charges by an insurer for the activities of an employee
5 who supervises outside vocational rehabilitation services shall not
6 exceed the vocational rehabilitation fee schedule, and shall not be
7 counted against the overall cap for vocational rehabilitation or the
8 limit on counselor's fees provided for in this section. These
9 charges shall be attributed as expenses by the insurer and not losses
10 for purposes of insurance rating pursuant to Article 2
11 (commencing with Section 11730) of Chapter 3 of Division 2 of
12 the Insurance Code.

13 (j) Any costs of an employer of supervising vocational
14 rehabilitation services shall not be counted against the overall cap
15 for vocational rehabilitation or the limit on counselor's fees
16 provided for in this section.

17 (k) This section shall only apply to injuries that occurred before
18 January 1, 2004.

19 3139.6. (a) The administrative director shall establish and
20 effect within the Division of Workers' Compensation a continuing
21 program to provide information and assistance concerning the
22 rights, benefits, and obligations of the workers' compensation law
23 to employees and employers subject thereto. The program shall
24 include, but not be limited to, the following:

25 (1) The preparation, publishing, and as necessary, updating, of
26 guides to the California workers' compensation system for
27 employees and employers. The guides shall detail, in easily
28 understandable language, the rights and obligations of employees
29 and employers, the procedures for obtaining benefits, and the
30 means provided for resolving disputes. Separate guides may be
31 prepared for employees and employers. The appropriate guide
32 shall be provided to all labor and employer organizations known
33 to the administrative director, and to any other person upon
34 request.

35 (2) The preparation, publishing, and as necessary, updating, of
36 a pamphlet advising injured workers of their basic rights under
37 workers' compensation law, and informing them of rights under
38 the Americans with Disabilities Act, and the provisions of the Fair
39 Employment and Housing Act relating to individuals with a
40 disability. The pamphlet shall be written in easily understandable



1 language. The pamphlet shall be available in both English and
2 Spanish, and shall include basic information concerning the
3 circumstances under which injured employees are entitled to the
4 various types of workers' compensation benefits, the protections
5 against discrimination because of an injury, the procedures for
6 resolving any disputes which arise, and the right to seek
7 information and advice from an information and assistance officer
8 or an attorney.

9 (b) In each district office of the division, the administrative
10 director shall appoint an information and assistance officer, and
11 any other deputy information and assistance officers as the work
12 of the district office may require. The administrative director shall
13 provide office facilities and clerical support appropriate to the
14 functions of these information and assistance officers.

15 (c) Each information and assistance officer shall be responsible
16 for the performance of the following duties:

17 (1) Providing continuing information concerning rights,
18 benefits, and obligations under workers' compensation laws to
19 injured workers, employers, lien claimants, and other interested
20 parties.

21 (2) Upon request by the injured worker, assisting in the prompt
22 resolution of misunderstanding, disputes, and controversies
23 arising out of claims for compensation, without formal
24 proceedings, in order that full and timely compensation benefits
25 shall be furnished. In performing this duty, information and
26 assistance officers shall not be responsible for reviewing
27 applications for adjudication or declarations of readiness to
28 proceed. This function shall be performed by workers'
29 compensation judges. This function may also be performed by
30 settlement conference referees upon delegation by the appeals
31 board.

32 (3) Distributing any information pamphlets in English and
33 Spanish as are prepared and approved by the administrative
34 director to all inquiring injured workers and any other parties that
35 may request copies of these pamphlets.

36 (4) Establishing and maintaining liaison with the persons
37 located in the geographic area served by the district office, with
38 other affected state agencies, and with organizations representing
39 employees, employers, insurers, and the medical community.



1 SEC. 3. The heading of Part 1 (commencing with Section
2 3200) of Division 4 of the Labor Code is amended and renumbered
3 to read:

4
5 PART 1.— 1.5. SCOPE AND OPERATION

6
7 SEC. 4. Section 3201.5 of the Labor Code is amended to read:

8 3201.5. (a) Except as provided in subdivisions (b) and (c),
9 the Department of Industrial Relations and the courts of this state
10 shall recognize as valid and binding any provision in a collective
11 bargaining agreement between a private employer or groups of
12 employers ~~engaged in construction, construction maintenance, or~~
13 ~~activities limited to rock, sand, gravel, cement and asphalt~~
14 ~~operations, heavy duty mechanics, surveying, and construction~~
15 ~~inspection~~ and a union that is the recognized or certified exclusive
16 bargaining representative that establishes any of the following:

17 (1) An alternative dispute resolution system governing
18 disputes between employees and employers or their insurers that
19 supplements or replaces all or part of those dispute resolution
20 processes contained in this division, including, but not limited to,
21 mediation and arbitration. Any system of arbitration shall provide
22 that the decision of the arbiter or board of arbitration is subject to
23 review by the appeals board in the same manner as provided for
24 reconsideration of a final order, decision, or award made and filed
25 by a workers' compensation administrative law judge pursuant to
26 the procedures set forth in Article 1 (commencing with Section
27 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals
28 pursuant to the procedures set forth in Article 2 (commencing with
29 Section 5950) of Chapter 7 of Part 4 of Division 4, governing
30 orders, decisions, or awards of the appeals board. The findings of
31 fact, award, order, or decision of the arbitrator shall have the same
32 force and effect as an award, order, or decision of a workers'
33 compensation administrative law judge. Any provision for
34 arbitration established pursuant to this section shall not be subject
35 to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

36 (2) The use of an agreed list of providers of medical treatment
37 that may be the exclusive source of all medical treatment provided
38 under this division.

39 (3) The use of an agreed, limited list of qualified medical
40 evaluators and agreed medical evaluators that may be the

[4]



1 exclusive source of qualified medical evaluators and agreed
2 medical evaluators under this division.

3 (4) Joint labor management safety committees.

4 (5) A light-duty, modified job or return-to-work program.

5 (6) A vocational rehabilitation or retraining program utilizing
6 an agreed list of providers of rehabilitation services that may be the
7 exclusive source of providers of rehabilitation services under this
8 division.

9 (b) Nothing in this section shall allow a collective bargaining
10 agreement that diminishes the entitlement of an employee to
11 compensation payments for total or partial disability, temporary
12 disability, vocational rehabilitation, or medical treatment fully
13 paid by the employer as otherwise provided in this division. The
14 portion of any agreement that violates this subdivision shall be
15 declared null and void.

16 (c) Subdivision (a) shall apply only to the following:

17 (1) An employer developing or projecting an annual workers'
18 compensation insurance premium, in California, of two hundred
19 fifty thousand dollars (\$250,000) or more, or any employer that
20 paid an annual workers' compensation insurance premium, in
21 California, of two hundred fifty thousand dollars (\$250,000) in at
22 least one of the previous three years.

23 (2) Groups of employers engaged in a workers' compensation
24 safety group complying with Sections 11656.6 and 11656.7 of the
25 Insurance Code, and established pursuant to a joint labor
26 management safety committee or committees, that develops or
27 projects annual workers' compensation insurance premiums of
28 two million dollars (\$2,000,000) or more.

29 (3) Employers or groups of employers that are self-insured in
30 compliance with Section 3700 that would have projected annual
31 workers' compensation costs that meet the requirements of, and
32 that meet the other requirements of, paragraph (1) in the case of
33 employers, or paragraph (2) in the case of groups of employers.

34 (4) Employers covered by an owner or general contractor
35 provided wrap-up insurance policy applicable to a single
36 construction site that develops workers' compensation insurance
37 premiums of two million dollars (\$2,000,000) or more with
38 respect to those employees covered by that wrap-up insurance
39 policy.



1 (d) Employers and labor representatives who meet the
2 eligibility requirements of this section shall be issued a letter by the
3 administrative director advising each employer and labor
4 representative that, based upon the review of all documents and
5 materials submitted as required by the administrative director,
6 each has met the eligibility requirements of this section.

7 (e) The premium rate for a policy of insurance issued pursuant
8 to this section shall not be subject to the requirements of Section
9 11732 or 11732.5 of the Insurance Code.

10 (f) No employer may establish or continue a program
11 established under this section until it has provided the
12 administrative director with all of the following:

13 (1) Upon its original application and whenever it is
14 renegotiated thereafter, a copy of the collective bargaining
15 agreement and the approximate number of employees who will be
16 covered thereby.

17 (2) Upon its original application and annually thereafter, a
18 valid and active license where that license is required by law as a
19 condition of doing business in the state within the industries set
20 forth in subdivision (a) of Section 3201.5.

21 (3) Upon its original application and annually thereafter, a
22 statement signed under penalty of perjury, that no action has been
23 taken by any administrative agency or court of the United States
24 to invalidate the collective bargaining agreement.

25 (4) The name, address, and telephone number of the contact
26 person of the employer.

27 (5) Any other information that the administrative director
28 deems necessary to further the purposes of this section.

29 (g) No collective bargaining representative may establish or
30 continue to participate in a program established under this section
31 unless all of the following requirements are met:

32 (1) Upon its original application and annually thereafter, it has
33 provided to the administrative director a copy of its most recent
34 LM-2 or LM-3 filing with the United States Department of Labor,
35 along with a statement, signed under penalty of perjury, that the
36 document is a true and correct copy.

37 (2) It has provided to the administrative director the name,
38 address, and telephone number of the contact person or persons of
39 the collective bargaining representative or representatives.



1 (h) Commencing July 1, 1995, and annually thereafter, the
2 Division of Workers' Compensation shall report to the Director of
3 the Department of Industrial Relations the number of collective
4 bargaining agreements received and the number of employees
5 covered by these agreements.

6 (i) By June 30, 1996, and annually thereafter, the
7 Administrative Director of the Division of Workers'
8 Compensation shall prepare and notify Members of the
9 Legislature that a report authorized by this section is available
10 upon request. The report based upon aggregate data shall include
11 the following:

12 (1) Person hours and payroll covered by agreements filed.

13 (2) The number of claims filed.

14 (3) The average cost per claim shall be reported by cost
15 components whenever practicable.

16 (4) The number of litigated claims, including the number of
17 claims submitted to mediation, the appeals board, or the court of
18 appeal.

19 (5) The number of contested claims resolved prior to
20 arbitration.

21 (6) The projected incurred costs and actual costs of claims.

22 (7) Safety history.

23 (8) The number of workers participating in vocational
24 rehabilitation.

25 (9) The number of workers participating in light-duty
26 programs.

27 The division shall have the authority to require those employers
28 and groups of employers listed in subdivision (c) to provide the
29 data listed above.

30 (j) The data obtained by the administrative director pursuant to
31 this section shall be confidential and not subject to public
32 disclosure under any law of this state. However, the Division of
33 Workers' Compensation shall create derivative works pursuant to
34 subdivisions (h) and (i) based on the collective bargaining
35 agreements and data. Those derivative works shall not be
36 confidential, but shall be public. On a monthly basis the
37 administrative director shall make available an updated list of
38 employers and unions entering into collective bargaining
39 agreements containing provisions authorized by this section.

40 SEC. 5. Section 3208 of the Labor Code is amended to read:



1 3208. “Injury” includes any injury or disease arising out of
2 the employment *that is certified by a physician using medical*
3 *evidence based on objective medical findings, as defined in*
4 *paragraph (2) of subdivision (j) of Section 3139.2, including*
5 *injuries to artificial members, dentures, hearing aids, eyeglasses,*
6 *and medical braces of all types; provided, however, that. However*
7 *eyeglasses and hearing aids will not be replaced, repaired, or*
8 *otherwise compensated for, unless injury to them is incident to an*
9 *injury causing disability.*

10 SEC. 6. Section 3208.1 of the Labor Code is amended to read:

11 3208.1. (a) An injury may be either: ~~(a) “specific,”~~ of the
12 *following:*

13 (1) “*Specific*” and thus occurring as the result of one incident
14 or exposure ~~which~~ *that* causes disability or need for medical
15 treatment; ~~or (b) “cumulative,”~~.

16 (2) “*Cumulative*” and thus occurring as repetitive mentally or
17 physically traumatic activities extending over a period of time, the
18 combined effect of which causes any disability or need for medical
19 treatment. ~~The~~

20 (b) *The* date of a cumulative injury shall be the date determined
21 under Section 5412.

22 (c) *In order to establish that a cumulative injury is*
23 *compensable, an employee shall demonstrate by a preponderance*
24 *of the medical evidence, that the injury was substantially caused*
25 *by actual activities of employment.*

26 (d) *In order to establish that a specific injury is compensable,*
27 *an employee shall demonstrate that the injury has contributed at*
28 *least 10 percent to the cause of the disability or death when*
29 *compared to all causes of injury in total.*

30 (e) *Notwithstanding any other provision of law, an injury shall*
31 *not be considered compensable if the person was injured while*
32 *incarcerated or imprisoned in a county jail or the state prison.*

33 SEC. 7. Section 3209.3 of the Labor Code is amended to read:

34 3209.3. (a) “Physician” includes physicians and surgeons
35 holding an M.D. or D.O. degree, psychologists, acupuncturists,
36 optometrists, dentists, podiatrists, and chiropractic practitioners
37 licensed by California state law and within the scope of their
38 practice as defined by California state law.

39 (b) “Psychologist” means a licensed psychologist with a
40 doctoral degree in psychology, or a doctoral degree deemed



1 equivalent for licensure by the Board of Psychology pursuant to
2 Section 2914 of the Business and Professions Code, and who either
3 has at least two years of clinical experience in a recognized health
4 setting or has met the standards of the National Register of the
5 Health Service Providers in Psychology.

6 (c) When treatment or evaluation for an injury is provided by
7 a psychologist, provision shall be made for appropriate medical
8 collaboration when requested by the employer or the insurer.

9 (d) “Acupuncturist” means a person who holds an
10 acupuncturist’s certificate issued pursuant to Chapter 12
11 (commencing with Section 4925) of Division 2 of the Business and
12 Professions Code.

13 ~~(e) Nothing in this section shall be construed to authorize~~
14 ~~acupuncturists to~~ ‘Chiropractic practitioner’ means a person who
15 holds a certificate to practice chiropractic issued pursuant to the
16 Chiropractic Act.

17 (f) Notwithstanding subdivision (a) and any other provision of
18 law, an acupuncturist and a chiropractic practitioner may not
19 determine disability for the purposes of Article 3 (commencing
20 with Section 4650) of Chapter 2 of Part 2, or under Section 2708
21 of the Unemployment Insurance Code.

22 SEC. 7.5. Section 3600 of the Labor Code is amended to read:

23 3600. (a) Liability ~~for the compensation~~ provided by this
24 division, in lieu of any other liability whatsoever to any person
25 except as otherwise specifically provided in Sections 3602, 3706,
26 and 4558, shall, without regard to negligence, exist against an
27 employer, *including* for any injury sustained by his or her
28 employees arising out of and in the course of the employment and
29 for the death of any employee if the injury proximately causes
30 death, in those cases where the following conditions of
31 compensation concur:

32 (1) Where, at the time of the injury, both the employer and the
33 employee are subject to the compensation provisions of this
34 division *and where the employer and employee are not subject to*
35 *a rule of liability for injury or death arising out of and in the course*
36 *of employment provided by the laws of the United States.*

37 (2) Where, at the time of the injury, the employee is performing
38 service growing out of and incidental to his or her employment and
39 is acting within the course of his or her employment.



- 1 (3) Where the injury is proximately caused by the employment,
- 2 either with or without negligence.
- 3 (4) Where the injury is not caused by the intoxication, by
- 4 alcohol or the unlawful use of a controlled substance, of the injured
- 5 employee. As used in this paragraph, “controlled substance” shall
- 6 have the same meaning as prescribed in Section 11007 of the
- 7 Health and Safety Code.
- 8 (5) Where the injury is not intentionally self-inflicted.
- 9 (6) Where the employee has not willfully and deliberately
- 10 caused his or her own death.
- 11 (7) Where the injury does not arise out of an altercation in
- 12 which the injured employee is the initial physical aggressor.
- 13 (8) Where the injury is not caused by the commission of a
- 14 felony, or a crime which is punishable as specified in subdivision
- 15 (b) of Section 17 of the Penal Code, by the injured employee, for
- 16 which he or she has been convicted.
- 17 (9) Where the injury does not arise out of voluntary
- 18 participation in any off-duty recreational, social, or athletic
- 19 activity not constituting part of the employee’s work-related
- 20 duties, except where these activities are a reasonable expectancy
- 21 of, or are expressly or impliedly required by, the employment. The
- 22 administrative director shall promulgate reasonable rules and
- 23 regulations requiring employers to post and keep posted in a
- 24 conspicuous place or places a notice advising employees of the
- 25 provisions of this subdivision. Failure of the employer to post the
- 26 notice shall not constitute an expression of intent to waive the
- 27 provisions of this subdivision.
- 28 (10) Except for psychiatric injuries governed by subdivision
- 29 (e) of Section 3208.3, where the claim for compensation is filed
- 30 after notice of termination or layoff, including voluntary layoff,
- 31 and the claim is for an injury occurring prior to the time of notice
- 32 of termination or layoff, no compensation shall be paid unless the
- 33 employee demonstrates by a preponderance of the evidence that
- 34 one or more of the following conditions apply:
- 35 (A) The employer has notice of the injury, as provided under
- 36 Chapter 2 (commencing with Section 5400), prior to the notice of
- 37 termination or layoff.
- 38 (B) The employee’s medical records, existing prior to the
- 39 notice of termination or layoff, contain evidence of the injury.



1 (C) The date of injury, as specified in Section 5411, is
2 subsequent to the date of the notice of termination or layoff, but
3 prior to the effective date of the termination or layoff.

4 (D) The date of injury, as specified in Section 5412, is
5 subsequent to the date of the notice of termination or layoff.

6 For purposes of this paragraph, an employee provided notice
7 pursuant to Sections 44948.5, 44949, 44951, 44955, 44955.6,
8 72411, 87740, and 87743 of the Education Code shall be
9 considered to have been provided a notice of termination or layoff
10 only upon a district's final decision not to reemploy that person.

11 A notice of termination or layoff that is not followed within 60
12 days by that termination or layoff shall not be subject to the
13 provisions of this paragraph, and this paragraph shall not apply
14 until receipt of a later notice of termination or layoff. The issuance
15 of frequent notices of termination or layoff to an employee shall
16 be considered a bad faith personnel action and shall make this
17 paragraph inapplicable to the employee.

18 (b) Where an employee, or his or her dependents, receives the
19 compensation provided by this division and secures a judgment
20 for, or settlement of, civil damages pursuant to those specific
21 exemptions to the employee's exclusive remedy set forth in
22 subdivision (b) of Section 3602 and Section 4558, the
23 compensation paid under this division shall be credited against the
24 judgment or settlement, and the employer shall be relieved from
25 the obligation to pay further compensation to, or on behalf of, the
26 employee or his or her dependents up to the net amount of the
27 judgment or settlement received by the employee or his or her
28 heirs, or that portion of the judgment as has been satisfied.

29 SEC. 8. Article 2.3 (commencing with Section 3737) is added
30 to Chapter 4 of Part 1.5 of Division 4 of the Labor Code, to read:

31

32 Article 2.3. Private Self-Insurance Groups

33

34 3737. For purposes of establishing the ability of a private
35 self-insured group to self-insure and pay compensation that may
36 become due under Section 3700, the following shall apply:

37 (a) A new member employer to a self-insured group shall not
38 be required to provide certified independently audited financials
39 if the group has reached and maintains a consolidated net worth of
40 five million dollars (\$5,000,000). However, the new member's



1 financials may be required to be reviewed as provided by the
2 department.

3 (b) A new member employer to a self-insured group shall not
4 be required to have its financials reviewed by the department if the
5 group has reached and maintains a net worth of ten million dollars
6 (\$10,000,000).

7 3737.3. (a) A private self-insured group may admit a new
8 member employer, subject to the application for membership
9 being approved by the department within 30 days of the
10 admittance.

11 (b) If the department denies the application for membership,
12 the employer shall leave the group and find coverage elsewhere
13 within 30 to 60 days of the denial of application, as determined by
14 the department.

15 (c) A private self-insured group that elects to accept new
16 member employers prior to the approval of an application by the
17 department shall do so pursuant to bylaws adopted to address this
18 category of membership.

19 (d) An administrator of a self-insured group that demonstrates
20 an inability to manage the procedures established pursuant to this
21 section and the bylaws of the private self-insured group for
22 admitting a new member employer to an existing self-insured
23 group may be fined or disciplined by the department.

24 3737.5. Notwithstanding any other provisions of law, an
25 agreement between a private self-insured group and any entity to
26 administer a group self-insurance plan or provide marketing or
27 claims handling services to that private self-insured group, if the
28 agreement is for a term of five years or less and the total of all
29 operating expenses does not exceed maximum expense,
30 established by the department by regulation, shall be presumed
31 valid and deemed approved if the agreement has been fully
32 disclosed to each member employer of the group and signed by
33 legal counsel representing the founding members of the group
34 self-insurer.

35 3737.7. (a) A private self-insured group may self-insure a
36 group of employers that are engaged in a common trade or
37 business as provided in this section. Such a private self-insured
38 group shall file with the department a statement that complies with
39 the conditions set forth in paragraph (3) of subdivision (a) of
40 Section 11656.6 of the Insurance Code.



1 (b) For purposes of this section, “common trade or business”
2 has the same meaning as provided in subdivision (b) of Section
3 11656.6 of the Insurance Code.

4 3737.8. This article shall be operative on the date the
5 Insurance Commissioner certifies to the Secretary of State that this
6 article is consistent with the model act of the National Association
7 of Insurance Commissioners.

8 SEC. 9. Section 4060 of the Labor Code is amended to read:

9 4060. (a) This section shall *only* apply to disputes over the
10 compensability of any injury. This section shall not apply where
11 injury to any part or parts of the body is accepted as compensable
12 by the employer.

13 (b) Neither the employer nor the employee shall be liable for
14 any comprehensive medical-legal evaluation performed by other
15 than the treating physician either in whole or in part on behalf of
16 the employee prior to the filing of a claim form and prior to the
17 time the claim is denied or becomes presumptively compensable
18 under Section 5402. However, reports of treating physicians shall
19 be admissible.

20 (c) If a medical evaluation is required to determine
21 compensability at any time after the period specified in
22 subdivision (b), and the employee is represented by an attorney,
23 each party may select a qualified medical evaluator to conduct a
24 comprehensive medical-legal evaluation. Neither party may
25 obtain more than one comprehensive medical-legal report,
26 provided, however, that any party may obtain additional reports at
27 their own expense. The parties may, at any time, agree on one
28 medical evaluator to evaluate the issues in dispute.

29 (d) If a medical evaluation is required to determine
30 compensability at any time after the period specified in
31 subdivision (b), and the employee is not represented by an
32 attorney, the employer shall not seek agreement with the employee
33 on a physician to prepare a comprehensive medical-legal
34 evaluation. The employee may select a qualified medical evaluator
35 to prepare a comprehensive medical-legal evaluation. The
36 division shall assist unrepresented employees, and shall make
37 available to them the list of medical evaluators compiled under
38 Section ~~139.2~~ 3139.2. Neither party may obtain more than one
39 comprehensive medical-legal report, provided, however, that any
40 party may obtain additional reports at their own expense. If an



1 employee has received a comprehensive medical-legal evaluation
2 under this subdivision, and he or she later becomes represented by
3 an attorney, he or she shall not be entitled to an additional
4 evaluation at the employer's expense.

5 (e) Evaluations performed under this section shall ~~not~~ be
6 limited to the issue of the compensability of the injury, ~~but shall~~
7 ~~address all medical issues in dispute.~~

8 SEC. 10. Section 4061 of the Labor Code is amended to read:

9 4061. (a) Together with the last payment of temporary
10 disability indemnity, the employer shall, in a form prescribed by
11 the administrative director pursuant to Section ~~138.4~~ 3138.4,
12 provide the employee one of the following:

13 (1) Notice either that no permanent disability indemnity will be
14 paid because the employer alleges the employee has no permanent
15 impairment or limitations resulting from the injury or notice of the
16 amount of permanent disability indemnity determined by the
17 employer to be payable. The notice shall include information
18 concerning how the employee may obtain a formal medical
19 evaluation pursuant to subdivision (c) if he or she disagrees with
20 the position taken by the employer. The notice shall be
21 accompanied by the form prescribed by the ~~Industrial Medical~~
22 ~~Council~~ *administrative director* for requesting assignment of a
23 panel of qualified medical evaluators, unless the employee is
24 represented by an attorney. If the employer determines permanent
25 disability indemnity is payable, the employer shall advise the
26 employee of the amount determined payable and the basis on
27 which the determination was made and whether there is need for
28 continuing medical care.

29 (2) Notice that permanent disability indemnity may be or is
30 payable, but that the amount cannot be determined because the
31 employee's medical condition is not yet permanent and stationary.
32 The notice shall advise the employee that his or her medical
33 condition will be monitored until it is permanent and stationary, at
34 which time the necessary evaluation will be performed to
35 determine the existence and extent of permanent impairment and
36 limitations for the purpose of rating permanent disability and to
37 determine the need for continuing medical care, or at which time
38 the employer will advise the employee of the amount of permanent
39 disability indemnity the employer has determined to be payable.
40 If an employee is provided notice pursuant to this paragraph and



1 the employer later takes the position that the employee has no
2 permanent impairment or limitations resulting from the injury, or
3 later determines permanent disability indemnity is payable, the
4 employer shall in either event, within 14 days of the determination
5 to take either position, provide the employee with the notice
6 specified in paragraph (1).

7 (b) Each notice required by subdivision (a) shall describe the
8 administrative procedures available to the injured employee and
9 advise the employee of his or her right to consult an information
10 and assistance officer or an attorney. It shall contain the following
11 language:

12 “Should you decide to be represented by an attorney, you may
13 or may not receive a larger award, but, unless you are determined
14 to be ineligible for an award, the attorney’s fee will be deducted
15 from any award you might receive for disability benefits. The
16 decision to be represented by an attorney is yours to make, but it
17 is voluntary and may not be necessary for you to receive your
18 benefits.”

19 (c) If the parties do not agree to a permanent disability rating
20 based on the treating physician’s evaluation or the assessment of
21 need for continuing medical care, and the employee is represented
22 by an attorney, the employer shall seek agreement with the
23 employee on a physician to prepare a comprehensive medical
24 evaluation of the employee’s permanent impairment and
25 limitations and any need for continuing medical care resulting
26 from the injury. If no agreement is reached within 10 days, or any
27 additional time not to exceed 20 days agreed to by the parties, the
28 parties may not later select an agreed medical evaluator.
29 Evaluations of an employee’s permanent impairment and
30 limitations obtained prior to the period to reach agreement shall
31 not be admissible in any proceeding before the appeals board.
32 After the period to reach agreement has expired, either party may
33 select a qualified medical evaluator to conduct the comprehensive
34 medical evaluation. Neither party may obtain more than one
35 comprehensive medical-legal report, provided, however, that any
36 party may obtain additional reports at their own expense.

37 (d) (1) If the parties do not agree to a permanent disability
38 rating based on the treating physician’s evaluation, and if the
39 employee is not represented by an attorney, the employer shall not
40 seek agreement with the employee on a physician to prepare an



1 additional medical evaluation. ~~The employer shall immediately~~
2 ~~provide the employee with a form prescribed by the medical~~
3 ~~director with which to request assignment of a panel of three~~
4 ~~qualified medical evaluators.~~ *The employer shall immediately*
5 *request assignment of a panel of three qualified medical evaluators*
6 *from the medical director and notify the employee of the request on*
7 *a form prescribed by the administrator director. A copy of the*
8 *treating physician's evaluation shall be included with the request.*
9 *Within 30 days of receipt of notice of the assignment of the panel*
10 *from the medical director, the employee shall select a physician*
11 *from the panel to prepare a medical evaluation of the employee's*
12 *permanent impairment and limitations and any need for*
13 *continuing medical care resulting from the injury.*

14 ~~For injury.~~ *If a comprehensive medical legal evaluation has*
15 *been prepared by the treating physician, and no good cause exists,*
16 *as defined in subdivision (g), for the failure of the employee to*
17 *select a qualified medical evaluator within the 30-day time period*
18 *set forth in this subdivision, or, if no assignment of a panel has been*
19 *made by the medical director within the timeframes required by*
20 *subdivision (h) of Section 3139.2 and the employee has failed to*
21 *select a qualified medical evaluator within 45 days of receipt of the*
22 *notice from the employer that a panel has been requested, issues*
23 *relating to the existence or extent of permanent impairment and*
24 *limitations or the need for continuing medical care resulting from*
25 *the injury may be the subject of a declaration of readiness to*
26 *proceed.*

27 (2) ~~For injuries occurring on or after January 1, 2003, except~~
28 ~~as provided in subdivision (b) of Section 4064,~~ the report of the
29 qualified medical evaluator and the reports of the treating
30 physician or physicians shall be the only admissible reports and
31 shall be the only reports obtained by the employee or the employer
32 on the issues subject to this section.

33 (e) If an employee obtains a qualified medical evaluator from
34 a panel pursuant to subdivision (d) or pursuant to subdivision (b)
35 of Section 4062, and thereafter becomes represented by an
36 attorney and obtains an additional qualified medical evaluator, the
37 employer shall have a corresponding right to secure an additional
38 qualified medical evaluator.

39 (f) The represented employee shall be responsible for making
40 an appointment with an agreed medical evaluator.



1 (g) The unrepresented employee shall ~~be responsible for~~
2 ~~making~~ make an appointment with a qualified medical evaluator
3 selected from a panel of three qualified medical evaluators *within*
4 *30 days of receipt of the notice of the assignment of the panel from*
5 *the medical director. If a comprehensive medical-legal evaluation*
6 *has been completed by the treating physician, and if no good cause*
7 *exists for the failure of the employee to schedule the evaluation,*
8 *issues relating to the existence or extent of permanent impairment*
9 *and limitations or the need for continuing medical care resulting*
10 *from the injury may be the subject of a declaration of readiness to*
11 *proceed.* The evaluator shall give the employee, at the
12 appointment, a brief opportunity to ask questions concerning the
13 evaluation process and the evaluator's background. The
14 unrepresented employee shall then participate in the evaluation as
15 requested by the evaluator unless the employee has good cause to
16 discontinue the evaluation. For purposes of this subdivision,
17 "good cause" shall include evidence that the evaluator is biased
18 against the employee because of his or her race, sex, national
19 origin, religion, or sexual preference or evidence that the evaluator
20 has requested the employee to submit to an unnecessary medical
21 examination or procedure. If the unrepresented employee declines
22 to proceed with the evaluation, he or she shall have the right to a
23 new panel of three qualified medical evaluators from which to
24 select one to prepare a comprehensive medical evaluation. If the
25 appeals board subsequently determines that the employee did not
26 have good cause to not proceed with the evaluation, the cost of the
27 evaluation shall be deducted from any award the employee
28 obtains.

29 (h) Upon selection or assignment pursuant to subdivision (c) or
30 (d), the medical evaluator shall perform a comprehensive ~~medical~~
31 *medical-legal* evaluation according to the procedures
32 ~~promulgated~~ *adopted* by the ~~Industrial Medical Council~~
33 *administrative director* under paragraphs (2) and (3) of
34 subdivision (j) of Section ~~139.2~~ *3139.2* and summarize the
35 ~~medical~~ findings on a form prescribed by the ~~Industrial Medical~~
36 ~~Council~~ *administrative director.* The comprehensive ~~medical~~
37 *medical-legal* evaluation shall address all contested ~~medical~~
38 *regarding the employee's permanent impairment and limitations*
39 *and any need for continuing medical care* arising from all injuries
40 reported on one or more claim forms prior to the date of the



1 employee's initial appointment with the medical evaluator. If,
2 after a comprehensive~~medical~~ *medical-legal* evaluation is
3 prepared, the employer or the employee subsequently objects to
4 any new~~medical~~ issue *regarding the employee's permanent*
5 *impairment and limitations and any need for continuing medical*
6 *care*, the parties, to the extent possible, shall utilize the same
7 medical evaluator who prepared the previous evaluation to resolve
8 the medical dispute.

9 (i) Except as provided in Section~~139.3~~ *3139.3*, the medical
10 evaluator may obtain consultations from other physicians who
11 have treated the employee for the injury whose expertise is
12 necessary to provide a complete and accurate evaluation.

13 (j) The qualified medical evaluator who has evaluated an
14 unrepresented employee shall serve the comprehensive medical
15 evaluation and the summary form on the employee, employer, and
16 the administrative director. The unrepresented employee or the
17 employer may submit the treating physician's evaluation for the
18 calculation of a permanent disability rating. Within 20 days of
19 receipt of the comprehensive medical evaluation, the
20 administrative director shall calculate the permanent disability
21 rating according to Section 4660 and serve the rating on the
22 employee and employer.

23 (k) Any comprehensive medical evaluation concerning an
24 unrepresented employee which indicates that part or all of an
25 employee's permanent impairment or limitations may be subject
26 to apportionment pursuant to Sections 4663 or 4750 shall first be
27 submitted by the administrative director to a workers'
28 compensation judge who may refer the report back to the qualified
29 medical evaluator for correction or clarification if the judge
30 determines the proposed apportionment is inconsistent with the
31 law.

32 (l) Within 30 days of receipt of the rating, if the employee is
33 unrepresented, the employee or employer may request that the
34 administrative director reconsider the recommended rating or
35 obtain additional information from the treating physician or
36 medical evaluator to address issues not addressed or not
37 completely addressed in the original comprehensive medical
38 evaluation or not prepared in accord with the procedures of the
39 ~~Industrial Medical Council promulgated~~ *administrative director*
40 *adopted* under paragraph (2) or (3) of subdivision (j) of Section



1 ~~139.2~~ 3139.2. This request shall be in writing, shall specify the
2 reasons the rating should be reconsidered, and shall be served on
3 the other party. If the administrative director finds the
4 comprehensive medical evaluation is not complete or not in
5 compliance with the required procedures, the administrative
6 director shall return the report to the treating physician or qualified
7 medical evaluator for appropriate action as the administrative
8 director instructs. Upon receipt of the treating physician's or
9 qualified medical evaluator's final comprehensive medical
10 evaluation and summary form, the administrative director shall
11 recalculate the permanent disability rating according to Section
12 4660 and serve the rating, the comprehensive medical evaluation,
13 and the summary form on the employee and employer.

14 (m) If a comprehensive medical evaluation from the treating
15 physician or an agreed medical evaluator or a qualified medical
16 evaluator selected from a three-member panel resolves any issue
17 so as to require an employer to provide compensation, the
18 employer shall commence the payment of compensation or
19 promptly commence proceedings before the appeals board to
20 resolve the dispute. If the employee and employer agree to a
21 stipulated findings and award as provided under Section 5702 or
22 to compromise and release the claim under Chapter 2
23 (commencing with Section 5000) of Part 3, or if the employee
24 wishes to commute the award under Chapter 3 (commencing with
25 Section 5100) of Part 3, the appeals board shall first determine
26 whether the agreement or commutation is in the best interests of
27 the employee and whether the proper procedures have been
28 followed in determining the permanent disability rating. The
29 administrative director shall promulgate a form to notify the
30 employee, at the time of service of any rating under this section,
31 of the options specified in this subdivision, the potential
32 advantages and disadvantages of each option, and the procedure
33 for disputing the rating.

34 (n) No issue relating to the existence or extent of permanent
35 impairment and limitations or the need for continuing medical care
36 resulting from the injury may be the subject of a declaration of
37 readiness to proceed unless there has first been a medical
38 evaluation by a treating physician or an agreed or qualified
39 medical evaluator. With the exception of an evaluation or
40 evaluations prepared by the treating physician or physicians, no



1 evaluation of permanent impairment and limitations or need for
2 continuing medical care resulting from the injury shall be obtained
3 prior to service of the comprehensive medical evaluation on the
4 employee and employer if the employee is unrepresented, or prior
5 to the attempt to select an agreed medical evaluator if the employee
6 is represented. Evaluations obtained in violation of this
7 prohibition shall not be admissible in any proceeding before the
8 appeals board. However, the testimony, records, and reports
9 offered by the treating physician or physicians who treated the
10 employee for the injury and comprehensive medical evaluations
11 prepared by a qualified medical evaluator selected by an
12 unrepresented employee from a three-member panel shall be
13 admissible.

14 SEC. 10.5. Section 4062 of the Labor Code is amended to
15 read:

16 4062. (a) If either the employee or employer objects to a
17 ~~medical~~ determination made by the treating physician concerning
18 ~~the permanent and stationary status of the employee's medical~~
19 ~~condition,~~ the employee's preclusion or likely preclusion to
20 engage in his or her usual occupation, ~~the extent and scope of~~
21 ~~medical treatment,~~ or the existence of new and further disability,
22 ~~or any other medical issues not covered by Section 4060 or 4061,~~
23 the objecting party shall notify the other party in writing of the
24 objection within 20 days of receipt of the report if the employee
25 is represented by an attorney or within 30 days of receipt of the
26 report if the employee is not represented by an attorney. These time
27 limits may be extended for good cause or by mutual agreement. If
28 the employee is represented by an attorney, the parties shall seek
29 agreement with the other party on a physician, who need not be a
30 qualified medical evaluator, to prepare a report resolving the
31 disputed issue. If no agreement is reached within 10 days, or any
32 additional time not to exceed 20 days agreed upon by the parties,
33 the parties may not later select an agreed medical evaluator.
34 Evaluations obtained prior to the period to reach agreement shall
35 not be admissible in any proceeding before the appeals board.
36 After the period to reach agreement has expired, the objecting
37 party may select a qualified medical evaluator to conduct the
38 comprehensive medical evaluation. Neither party may obtain
39 more than one comprehensive medical-legal report, provided,
40 however, that any party may obtain additional reports at their own



1 expense. The nonobjecting party may continue to rely on the
2 treating physician's report or may select a qualified medical
3 evaluator to conduct an additional evaluation.

4 (b) (1) If the employee is not represented by an attorney, the
5 employer shall not seek agreement with the employee on a
6 physician to prepare the comprehensive medical evaluation. ~~The~~
7 ~~employer shall immediately provide the employee with a form~~
8 ~~prescribed by the medical director with which to request~~
9 ~~assignment of a panel of three qualified medical evaluators.~~ The
10 *employer shall immediately request assignment of a panel of three*
11 *qualified medical evaluators from the medical director and notify*
12 *the employee of the request on a form prescribed by the*
13 *administrative director. A copy of the treating physician's*
14 *evaluation shall be included with the request. Within 30 days of*
15 *receipt of notice of the assignment of the panel from the medical*
16 *director, the employee shall select a physician from the panel to*
17 *prepare a comprehensive medical evaluation. For* ~~If no good cause~~
18 ~~exists, as defined in subdivision (g) of Section 4061, for the failure~~
19 ~~of the employee to select a qualified medical evaluator within the~~
20 ~~30-day time period set forth in this subdivision, or, in no~~
21 ~~assignment of a panel has been made by the medical director~~
22 ~~within the timeframes required by subdivision (h) of Section~~
23 ~~3139.2 and the employee has failed to select a qualified medical~~
24 ~~evaluator within 45 days of receipt of the notice from the employer~~
25 ~~that a panel has been requested, issues relating to the existence or~~
26 ~~extent of permanent impairment and limitations or the need for~~
27 ~~continuing medical care resulting from the injury may be the~~
28 ~~subject of a declaration of readiness to proceed.~~

29 (2) For injuries occurring on or after January 1, 2003, except
30 as provided in subdivision (b) of Section 4064, the evaluation of
31 the qualified medical evaluator selected from a panel of three and
32 the reports of the treating physician or physicians shall be the only
33 admissible reports and shall be the only reports obtained by the
34 employee or employer on issues subject to this section in a case
35 involving an unrepresented employee.

36 (c) ~~Upon completing a determination of the disputed medical~~
37 ~~issue, the physician selected under subdivision (a) or (b) to~~
38 ~~perform the medical evaluation shall summarize the medical~~
39 ~~findings on a form prescribed by the Industrial Medical Council~~
40 ~~and shall serve the formal medical evaluation and the summary~~



1 form on the employee, employer, and administrative director. The
2 medical evaluation shall address all contested medical issues
3 arising from all injuries reported on one or more claim forms prior
4 to the date of the employee's initial appointment with the medical
5 evaluator. If, after a medical evaluation is prepared, the employer
6 or the employee subsequently objects to any new medical issue,
7 the parties, to the extent possible, shall utilize the same medical
8 evaluator who prepared the previous evaluation to resolve the
9 medical dispute.

10 (d) No disputed medical issue specified in subdivision (a) may
11 be the subject of a declaration of readiness to proceed unless there
12 has first been an evaluation by the treating physician or an agreed
13 or qualified medical evaluator.

14 (e) With the exception of a report or reports prepared by the
15 treating physician or physicians, no report determining disputed
16 medical issues set forth in subdivision (a) shall be obtained prior
17 to the expiration of the period to reach agreement on the selection
18 of an agreed medical evaluator under subdivision (a). Reports
19 obtained in violation of this prohibition shall not be admissible in
20 any proceeding before the appeals board. However, the testimony,
21 records, and reports offered by the treating physician or physicians
22 who treated the employee for the injury shall be admissible.

23 SEC. 11. Section 4062.5 of the Labor Code is amended to
24 read:

25 4062.5. If a qualified medical evaluator selected by an
26 unrepresented employee from a three-member panel fails to
27 complete the formal medical evaluation within the ~~time frames~~
28 *timeframes* established by the ~~Industrial Medical Council~~
29 *administrative director* pursuant to paragraph (1) of subdivision (j)
30 of Section ~~139.2~~ 3139.2, the employee shall have the right to a new
31 panel of three qualified medical evaluators from which to select
32 one to prepare a formal medical evaluation. Neither the employee
33 nor the employer shall have any liability for payment for the
34 formal medical evaluation which was not completed within the
35 required timeframes unless the employee, on a form prescribed by
36 the ~~Industrial Medical Council~~ *administrative director*, waives his
37 or her right to a new evaluation and elects to accept the original
38 evaluation even though it was not completed within the required
39 timeframes.

40 SEC. 12. Section 4062.9 of the Labor Code is repealed.



1 ~~4062.9. (a) For injuries occurring on or after January 1, 2003,~~
 2 ~~in cases where an additional comprehensive medical evaluation is~~
 3 ~~obtained under Section 4061 or 4062, if the employee has been~~
 4 ~~treated by his or her personal physician, or by his or her personal~~
 5 ~~chiropractor, as defined in Section 4601, who was predesignated~~
 6 ~~prior to the date of injury as provided under Section 4600, the~~
 7 ~~findings of the personal physician or personal chiropractor are~~
 8 ~~presumed to be correct. This presumption is rebuttable and may be~~
 9 ~~controverted by a preponderance of medical opinion indicating a~~
 10 ~~different level of disability. However, the presumption shall not~~
 11 ~~apply where both parties select qualified medical examiners.~~

12 ~~(b) The administrative director, in consultation with the~~
 13 ~~Industrial Medical Council, shall develop, not later than January~~
 14 ~~1, 2004, and periodically revise as necessary thereafter,~~
 15 ~~educational materials to be used to provide treating physicians and~~
 16 ~~chiropractors with information and training in basic concepts of~~
 17 ~~workers' compensation, the role of the treating physician, the~~
 18 ~~conduct of permanent and stationary evaluations, and report~~
 19 ~~writing.~~

20 SEC. 12.5. Section 4064 of the Labor Code is amended to
 21 read:

22 4064. (a) The employer shall be liable for the cost of each
 23 reasonable and necessary comprehensive medical-legal
 24 evaluation obtained by the employee pursuant to Sections 4060,
 25 4061, and 4062. Each comprehensive medical-legal evaluation
 26 shall address all contested medical issues arising from all injuries
 27 reported on one or more claim forms.

28 ~~(b) For injuries occurring on or after January 1, 2003, if an~~
 29 ~~unrepresented employee obtains an attorney after the evaluation~~
 30 ~~pursuant to subdivision (d) of Section 4061 or subdivision (b) of~~
 31 ~~Section 4062 has been completed, the employee shall be entitled~~
 32 ~~to the same reports at employer expense as an employee who has~~
 33 ~~been represented from the time the dispute arose and those reports~~
 34 ~~shall be admissible in any proceeding before the appeals board.~~

35 ~~(e) Subject to Section 4906, if an employer files an application~~
 36 ~~for adjudication and the employee is unrepresented at the time the~~
 37 ~~application is filed, the employer shall be liable for any attorney's~~
 38 ~~fees incurred by the employee in connection with the application~~
 39 ~~for adjudication.~~

40 ~~(d)~~



1 (c) The employer shall not be liable for the cost of any
2 comprehensive ~~medical~~ *medical-legal* evaluations obtained by the
3 employee other than those authorized pursuant to Sections 4060,
4 4061, and 4062. However, no party is prohibited from obtaining
5 any ~~medical~~ evaluation or consultation at the party's own expense.
6 In no event shall an employer or employee be liable for an
7 evaluation obtained in violation of subdivision (b) of Section
8 4060. All comprehensive ~~medical~~ *medical-legal* evaluations
9 obtained by any party shall be admissible in any proceeding before
10 the appeals board except as provided in subdivisions (d) and (m)
11 of Section 4061 and subdivisions (b) and (e) of Section 4062.

12 SEC. 13. Section 4068 of the Labor Code is amended to read:

13 4068. (a) Upon determining that a treating physician's report
14 contains opinions that are the result of conjecture, are not
15 supported by adequate evidence, or that indicate bias, the appeals
16 board shall so notify the administrative director in writing in a
17 manner he or she has specified.

18 (b) If the administrative director believes that any treating
19 physician's reports show a pattern of unsupported opinions, he or
20 she shall notify in writing the physician's applicable licensing
21 body of his findings. ~~If the treating physician is a medical~~
22 ~~evaluator, the administrative director shall also notify the~~
23 ~~Industrial Medical Council.~~

24 SEC. 14. Section 4600 of the Labor Code is amended to read:

25 4600. (a) Medical, surgical, chiropractic, acupuncture, and
26 hospital treatment, including nursing, medicines, medical and
27 surgical supplies, crutches, and apparatus, including orthotic and
28 prosthetic devices and services, that is reasonably required to cure
29 or relieve from the effects of the injury shall be provided by the
30 employer. In the case of his or her neglect or refusal seasonably to
31 do so, the employer is liable for the reasonable expense incurred
32 by or on behalf of the employee in providing treatment. ~~After~~

33 (b) (1) *As used in the division and notwithstanding any other*
34 *provision of law, medical treatment that is reasonably required to*
35 *cure or relieve the injured worker from the effects of his or her*
36 *injury means treatment that complies with all of the following:*

37 (A) *The treatment is in accordance with high-grade*
38 *evidence-based guidelines adopted by medical specialty*
39 *professional groups, or at a minimum, generally accepted*
40 *standards of medical practice that are based on credible scientific*



1 *evidence published in peer reviewed medical literature generally*
2 *recognized by the relevant medical community or evidence-based*
3 *medical treatment guidelines generally recognized by the medical*
4 *community.*

5 (B) *The treatment is clinically appropriate, in terms of safety,*
6 *type, frequency, extent, site, and duration, and considered effective*
7 *for the patient's injury.*

8 (C) *The treatment is not primarily for the convenience of the*
9 *patient, physician, or other health care provider, and not more*
10 *costly than an alternative service or sequence of services likely to*
11 *produce equivalent therapeutic or diagnostic results as to the*
12 *diagnosis or treatment of the injured worker's injury.*

13 (2) *Paragraph (1) shall apply to all treatment requested on or*
14 *after July 1, 2004, including treatment for injuries sustained prior*
15 *to that date.*

16 (c) *After 30 days from the date the injury is reported, the*
17 *employee may be treated by a physician of his or her own choice*
18 *or at a facility of his or her own choice within a reasonable*
19 *geographic area, only if the selection of the physician or facility is*
20 *mutually agreed to by the employer.* However, if an employee has
21 notified his or her employer in writing prior to the date of injury
22 that he or she has a personal physician *and the employer has agreed*
23 *to the choice*, the employee shall have the right to be treated by that
24 physician from the date of injury. If an employee requests a change
25 of physician pursuant to Section 4601, the request may be made
26 at any time after the injury, and the alternative physician,
27 chiropractor, or acupuncturist shall be provided within five days
28 of the request as required by Section 4601. For the purpose of this
29 section, "personal physician" means the employee's regular
30 physician and surgeon, licensed pursuant to Chapter 5
31 (commencing with Section 2000) of Division 2 of the Business and
32 Professions Code, who has previously directed the medical
33 treatment of the employee, and who retains the employee's
34 medical records, including his or her medical history.

35 ~~Where~~

36 (d) (1) *Where* at the request of the employer, the employer's
37 insurer, the administrative director, the appeals board, or a
38 workers' compensation judge, the employee submits to
39 examination by a physician, he or she shall be entitled to receive
40 in addition to all other benefits herein provided all reasonable



1 expenses of transportation, meals, and lodging incident to
2 reporting for the examination, together with one day of temporary
3 disability indemnity for each day of wages lost in submitting to the
4 examination. ~~Regardless~~

5 (2) *Regardless* of the date of injury, “reasonable expenses of
6 transportation” includes mileage fees from the employee’s home
7 to the place of the examination and back at the rate of twenty-one
8 cents (\$0.21) a mile or the mileage rate adopted by the Director of
9 the Department of Personnel Administration pursuant to Section
10 19820 of the Government Code, whichever is higher, plus any
11 bridge tolls. The mileage and tolls shall be paid to the employee
12 at the time he or she is given notification of the time and place of
13 the examination.

14 ~~Where~~

15 (e) *Where* at the request of the employer, the employer’s
16 insurer, the administrative director, the appeals board, a workers’
17 compensation judge, an employee submits to examination by a
18 physician and the employee does not proficiently speak or
19 understand the English language, he or she shall be entitled to the
20 services of a qualified interpreter in accordance with conditions
21 and a fee schedule prescribed by the administrative director. These
22 services shall be provided by the employer. For purposes of this
23 section, “qualified interpreter” means a language interpreter
24 certified, or deemed certified, pursuant to Article 8 (commencing
25 with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of
26 Title 2 of, or Section 68566 of, the Government Code.

27 (f) *This section shall not apply to employees and employers*
28 *covered under Section 4600.3 or 4600.31.*

29 SEC. 15. Section 4600.2 of the Labor Code is amended to
30 read:

31 4600.2. (a) ~~Notwithstanding~~ *In accordance with subdivision*
32 *(b) of Section 4600, when a self-insured employer, group of*
33 *self-insured employers, insurer of an employer, or group of*
34 *insurers contracts with a pharmacy, group of pharmacies, or*
35 *pharmacy benefit network to provide medicines and medical*
36 *supplies required by this article to be provided to injured*
37 *employees, those injured employees that are subject to the contract*
38 *shall be provided medicines and medical supplies in the manner*
39 *prescribed in the contract for as long as medicines or medical*
40 *supplies are reasonably required to cure or relieve the injured*



1 employee from the effects of the injury *as prescribed in Section*
2 *4600.*

3 (b) Nothing in this section shall affect the ability of
4 employee-selected physicians to continue to prescribe and have
5 the employer provide medicines and medical supplies that the
6 physicians deem reasonably required to cure or relieve the injured
7 employee from the effects of the injury *as prescribed in Section*
8 *4600.*

9 (c) Each contract described in subdivision (a) shall comply
10 with standards adopted by the administrative director. In adopting
11 those standards, the administrative director shall seek to reduce
12 pharmaceutical costs and may consult any relevant studies or
13 practices in other states. The standards shall provide for access to
14 a pharmacy within a reasonable geographic distance from an
15 injured employee's residence.

16 SEC. 16. Section 4600.3 of the Labor Code is repealed.

17 ~~4600.3. (a) (1) Notwithstanding Section 4600, when a~~
18 ~~self-insured employer, group of self-insured employers, or the~~
19 ~~insurer of an employer contracts with a health care organization~~
20 ~~certified pursuant to Section 4600.5 for health care services~~
21 ~~required by this article to be provided to injured employees, those~~
22 ~~employees who are subject to the contract shall receive medical~~
23 ~~services in the manner prescribed in the contract, providing that~~
24 ~~the employee may choose to be treated by a personal physician,~~
25 ~~personal chiropractor, or personal acupuncturist that he or she has~~
26 ~~designated prior to the injury, in which case the employee shall not~~
27 ~~be treated by the health care organization. Every employee shall~~
28 ~~be given an affirmative choice at the time of employment and at~~
29 ~~least annually thereafter to designate or change the designation of~~
30 ~~a health care organization or a personal physician, personal~~
31 ~~chiropractor, or personal acupuncturist. The choice shall be~~
32 ~~memorialized in writing and maintained in the employee's~~
33 ~~personnel records. The employee who has designated a personal~~
34 ~~physician, personal chiropractor, or personal acupuncturist may~~
35 ~~change their designated caregiver at any time prior to the injury.~~
36 ~~Any employee who fails to designate a personal physician,~~
37 ~~personal chiropractor, or personal acupuncturist shall be treated by~~
38 ~~the health care organization selected by the employer. If the health~~
39 ~~care organization offered by the employer is the workers'~~
40 ~~compensation insurer that covers the employee or is an entity that~~



1 controls or is controlled by that insurer, as defined by Section 1215
2 of the Insurance Code, this information shall be included in the
3 notice of contract with a health care organization.

4 (2) Each contract described in paragraph (1) shall comply with
5 the certification standards provided in Section 4600.5, and shall
6 provide all medical, surgical, chiropractic, acupuncture, and
7 hospital treatment, including nursing, medicines, medical and
8 surgical supplies, crutches, and apparatus, including artificial
9 members, that is reasonably required to cure or relieve the effects
10 of the injury, as required by this division, without any payment by
11 the employee of deductibles, copayments, or any share of the
12 premium. However, an employee may receive immediate
13 emergency medical treatment that is compensable from a medical
14 service or health care provider who is not a member of the health
15 care organization.

16 (3) Insured employers, a group of self-insured employers, or
17 self-insured employers who contract with a health care
18 organization for medical services shall give notice to employees
19 of eligible medical service providers and any other information
20 regarding the contract and manner of receiving medical services
21 as the administrative director may prescribe. Employees shall be
22 duly notified that if they choose to receive care from the health care
23 organization they must receive treatment for all occupational
24 injuries and illnesses as prescribed by this section.

25 (b) Notwithstanding subdivision (a), no employer which is
26 required to bargain with an exclusive or certified bargaining agent
27 which represents employees of the employer in accordance with
28 state or federal employer-employee relations law shall contract
29 with a health care organization for purposes of Section 4600.5 with
30 regard to employees whom the bargaining agent is recognized or
31 certified to represent for collective bargaining purposes pursuant
32 to state or federal employer-employee relations law unless
33 authorized to do so by mutual agreement between the bargaining
34 agent and the employer. If the collective bargaining agreement is
35 subject to the National Labor Relations Act, the employer may
36 contract with a health care organization for purposes of Section
37 4600.5 at any time when the employer and bargaining agent have
38 bargained to impasse to the extent required by federal law.

39 (c) (1) When an employee is not receiving or is not eligible to
40 receive health care coverage for nonoccupational injuries or



1 illnesses provided by the employer, if 90 days from the date the
2 injury is reported the employee who has been receiving treatment
3 from a health care organization or his or her physician,
4 chiropractor, acupuncturist, or other agent notifies his or her
5 employer in writing that he or she desires to stop treatment by the
6 health care organization, he or she shall have the right to be treated
7 by a physician, chiropractor, or acupuncturist or at a facility of his
8 or her own choosing within a reasonable geographic area.

9 (2) ~~When an employee is receiving or is eligible to receive~~
10 ~~health care coverage for nonoccupational injuries or illnesses~~
11 ~~provided by the employer, and has agreed to receive care for~~
12 ~~occupational injuries and illnesses from a health care organization~~
13 ~~provided by the employer, the employee may be treated for~~
14 ~~occupational injuries and diseases by a physician, chiropractor, or~~
15 ~~acupuncturist of his or her own choice or at a facility of his or her~~
16 ~~own choice within a reasonable geographic area if the employee~~
17 ~~or his or her physician, chiropractor, acupuncturist, or other agent~~
18 ~~notifies his or her employer in writing only after 180 days from the~~
19 ~~date the injury was reported, or upon the date of contract renewal~~
20 ~~or open enrollment of the health care organization, whichever~~
21 ~~occurs first, but in no case until 90 days from the date the injury~~
22 ~~was reported.~~

23 (3) ~~For purposes of this subdivision, an employer shall be~~
24 ~~deemed to provide health care coverage for nonoccupational~~
25 ~~injuries and illnesses if the employer pays more than one-half the~~
26 ~~costs of the coverage, or if the plan is established pursuant to~~
27 ~~collective bargaining.~~

28 (d) ~~An employee and employer may agree to other forms of~~
29 ~~therapy pursuant to Section 3209.7.~~

30 (e) ~~An employee enrolled in a health care organization shall~~
31 ~~have the right to no less than one change of physician on request,~~
32 ~~and shall be given a choice of physicians affiliated with the health~~
33 ~~care organization. The health care organization shall provide the~~
34 ~~employee a choice of participating physicians within five days of~~
35 ~~receiving a request. In addition, the employee shall have the right~~
36 ~~to a second opinion from a participating physician on a matter~~
37 ~~pertaining to diagnosis or treatment from a participating~~
38 ~~physician.~~

39 (f) ~~Nothing in this section or Section 4600.5 shall be construed~~
40 ~~to prohibit a self-insured employer, a group of self-insured~~



1 employers, or insurer from engaging in any activities permitted by
2 Section 4600.

3 ~~(g) Notwithstanding subdivision (e), in the event that the~~
4 ~~employer, group of employers, or the employer’s workers’~~
5 ~~compensation insurer no longer contracts with the health care~~
6 ~~organization that has been treating an injured employee, the~~
7 ~~employee may continue treatment provided or arranged by the~~
8 ~~health care organization. If the employee does not choose to~~
9 ~~continue treatment by the health care organization, the employer~~
10 ~~may control the employee’s treatment for 30 days from the date the~~
11 ~~injury was reported. After that period, the employee may be~~
12 ~~treated by a physician of his or her own choice or at a facility of~~
13 ~~his or her own choice within a reasonable geographic area.~~

14 SEC. 17. Section 4600.3 is added to the Labor Code, to read:

15 4600.3. (a) This section shall only apply to employees who
16 are eligible to receive health care coverage for nonoccupational
17 injuries or illnesses provided in whole or part by their employer.

18 (b) (1) A self-insured employer, group of self-insured
19 employers, or the insurer of an employer may contract with a
20 health care organization certified pursuant to Section 4600.5 for
21 health care services required by this article to be provided to
22 injured employees, and those employees who are subject to the
23 contract shall receive medical services in the manner prescribed in
24 the contract. An employer may contract for health care coverage
25 for nonoccupational injuries or illnesses with the same entity that
26 provides medical treatment required by this article. The employee
27 shall receive medical treatment in the manner prescribed in the
28 contract.

29 (2) The employee may choose to be treated by a personal
30 physician prior to the injury, in which case, the physician shall be
31 chosen from the list of medical providers authorized by the health
32 care organization.

33 (3) Each contract described in paragraph (1) shall comply with
34 the certification standards provided in Section 4600.5, and shall
35 provide all medically necessary treatment consistent with the
36 Knox-Keene Health Care Service Plan of 1975 (Chapter 2.2
37 (commencing with Section 1340) of Division 2 of the Health and
38 Safety Code), which shall be presumed to be treatment reasonably
39 required to cure or relieve the injured worker from the effects of
40 his or her injury. This presumption affects the burden of proof.

[4]



1 Notwithstanding any other provision of law, all services provided
2 by the health care organization, including those provided pursuant
3 to the organization’s utilization review and independent medical
4 review, shall also be presumed to be treatment reasonably required
5 to cure or relieve the injured worker from the effects of his or her
6 injury. This presumption affects the burden of proof.

7 (4) Notwithstanding any other provision of this section, an
8 employee may receive immediate emergency medical treatment
9 that is compensable from a medical service or health care provider
10 who is not a member of the health care organization.

11 (5) Notwithstanding any provision of this article, no employee
12 shall be required to pay any deductible, copayment, or any share
13 of the premium.

14 (c) An employee enrolled in a health care organization shall
15 have the right to no less than one change of physician on request
16 and for this purpose shall choose from physicians affiliated with
17 the health care organization. The health care organization shall
18 provide the employee with a choice of these participating
19 physicians within five days of receiving a request. In addition, the
20 employee shall have the right to a second opinion from a
21 participating physician on a matter pertaining to diagnosis or
22 treatment from a participating physician.

23 (d) Nothing in this section or Section 4600.5 shall be construed
24 to prohibit a self-insured employer, a group of self-insured
25 employers, or insurer from engaging in any activities permitted by
26 Section 4600.

27 (e) Notwithstanding subdivision (c), in the event that the
28 employer, group of employers, or the employer’s workers’
29 compensation insurer no longer contracts with the health care
30 organization that has been treating an injured employee, the
31 employee may continue treatment provided or arranged by the
32 health care organization for an additional 90 days.

33 SEC. 18. Section 4600.31 is added to the Labor Code, to read:

34 4600.31. (a) (1) A self-insured employer, group of
35 self-insured employers, or the insurer of an employer may contract
36 with a health care organization certified pursuant to Section
37 4600.5 for health care services required by this article to be
38 provided to injured employees, and those employees who are
39 subject to the contract shall receive medical services in the manner
40 prescribed in the contract. The employee shall receive medical



1 treatment in the manner prescribed in the contract that is consistent
2 with Section 4600.

3 (2) The employee may choose to be treated by a personal
4 physician prior to the injury, in which case, the physician shall be
5 chosen from the list of medical providers authorized by the health
6 care organization.

7 (3) Each contract described in paragraph (1) shall comply with
8 the certification standards provided in Section 4600.5, and shall
9 provide all medically necessary treatment consistent with Section
10 4600.

11 (4) Notwithstanding any other provision of this section, an
12 employee may receive immediate emergency medical treatment
13 that is compensable from a medical service or health care provider
14 who is not a member of the health care organization.

15 (5) Notwithstanding any provision of this article, no employee
16 shall be required to pay any deductible, copayment, or any share
17 of the premium.

18 (b) An employee enrolled in a health care organization shall
19 have the right to no less than one change of physician on request,
20 and for this purpose shall choose from physicians affiliated with
21 the health care organization. The health care organization shall
22 provide the employee with a choice of these participating
23 physicians within five days of receiving a request. In addition, the
24 employee shall have the right to a second opinion from a
25 participating physician on a matter pertaining to diagnosis or
26 treatment from a participating physician.

27 (c) Nothing in this section or Section 4600.5 shall be construed
28 to prohibit a self-insured employer, a group of self-insured
29 employers, or insurer from engaging in any activities permitted by
30 Section 4600.

31 (d) Notwithstanding subdivision (c), in the event that the
32 employer, group of employers, or the employer’s workers’
33 compensation insurer no longer contracts with the health care
34 organization that has been treating an injured employee, the
35 employee may continue treatment provided or arranged by the
36 health care organization for an additional 90 days.

37 SEC. 19. Section 4600.35 of the Labor Code is repealed.
38 ~~4600.35. Any entity seeking to reimburse health care~~
39 ~~providers for health care services rendered to injured workers on~~
40 ~~a capitated, or per person per month basis, shall be licensed~~



1 pursuant to the Knox-Keene Health Care Service Plan Act of 1975
2 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the
3 Health and Safety Code).

4 SEC. 20. Section 4600.5 of the Labor Code is repealed.

5 4600.5.—(a) Any health care service plan licensed pursuant to
6 the Knox-Keene Health Care Service Plan Act, a disability insurer
7 licensed by the Department of Insurance, or any entity, including,
8 but not limited to, workers' compensation insurers and third-party
9 administrators authorized by the administrative director under
10 subdivision (e), may make written application to the
11 administrative director to become certified as a health care
12 organization to provide health care to injured employees for
13 injuries and diseases compensable under this article.

14 (b) Each application for certification shall be accompanied by
15 a reasonable fee prescribed by the administrative director,
16 sufficient to cover the actual cost of processing the application. A
17 certificate is valid for the period that the director may prescribe
18 unless sooner revoked or suspended.

19 (c) If the health care organization is a health care service plan
20 licensed pursuant to the Knox-Keene Health Care Service Plan
21 Act, and has provided the Managed Care Unit of the Division of
22 Workers' Compensation with the necessary documentation to
23 comply with this subdivision, that organization shall be deemed to
24 be a health care organization able to provide health care pursuant
25 to Section 4600.3, without further application duplicating the
26 documentation already filed with the Department of Managed
27 Health Care. These plans shall be required to remain in good
28 standing with the Department of Managed Health Care, and shall
29 meet the following additional requirements:

30 (1) Proposes to provide all medical and health care services that
31 may be required by this article.

32 (2) Provides a program involving cooperative efforts by the
33 employees, the employer, and the health plan to promote
34 workplace health and safety, consultative and other services, and
35 early return to work for injured employees.

36 (3) Proposes a timely and accurate method to meet the
37 requirements set forth by the administrative director for all carriers
38 of workers' compensation coverage to report necessary
39 information regarding medical and health care service cost and
40 utilization, rates of return to work, average time in medical



1 ~~treatment, and other measures as determined by the administrative~~
2 ~~director to enable the director to determine the effectiveness of the~~
3 ~~plan.~~

4 ~~(4) Agrees to provide the administrative director with~~
5 ~~information, reports, and records prepared and submitted to the~~
6 ~~Department of Managed Health Care in compliance with the~~
7 ~~Knox Keene Health Care Service Plan Act, relating to financial~~
8 ~~solvency, provider accessibility, peer review, utilization review,~~
9 ~~and quality assurance, upon request, if the administrative director~~
10 ~~determines the information is necessary to verify that the plan is~~
11 ~~providing medical treatment to injured employees in compliance~~
12 ~~with the requirements of this code.~~

13 ~~Disclosure of peer review proceedings and records to the~~
14 ~~administrative director shall not alter the status of the proceedings~~
15 ~~or records as privileged and confidential communications~~
16 ~~pursuant to Sections 1370 and 1370.1 of the Health and Safety~~
17 ~~Code.~~

18 ~~(5) Demonstrates the capability to provide occupational~~
19 ~~medicine and related disciplines.~~

20 ~~(6) Complies with any other requirement the administrative~~
21 ~~director determines is necessary to provide medical services to~~
22 ~~injured employees consistent with the intent of this article,~~
23 ~~including, but not limited to, a written patient grievance policy.~~

24 ~~(d) If the health care organization is a disability insurer licensed~~
25 ~~by the Department of Insurance, and is in compliance with~~
26 ~~subdivision (d) of Sections 10133 and 10133.5 of the Insurance~~
27 ~~Code, the administrative director shall certify the organization to~~
28 ~~provide health care pursuant to Section 4600.3 if the director finds~~
29 ~~that the plan is in good standing with the Department of Insurance~~
30 ~~and meets the following additional requirements:~~

31 ~~(1) Proposes to provide all medical and health care services that~~
32 ~~may be required by this article.~~

33 ~~(2) Provides a program involving cooperative efforts by the~~
34 ~~employees, the employer, and the health plan to promote~~
35 ~~workplace health and safety, consultative and other services, and~~
36 ~~early return to work for injured employees.~~

37 ~~(3) Proposes a timely and accurate method to meet the~~
38 ~~requirements set forth by the administrative director for all carriers~~
39 ~~of workers' compensation coverage to report necessary~~
40 ~~information regarding medical and health care service cost and~~



1 utilization, rates of return to work, average time in medical
2 treatment, and other measures as determined by the administrative
3 director to enable the director to determine the effectiveness of the
4 plan.

5 (4) ~~Agrees to provide the administrative director with~~
6 ~~information, reports, and records prepared and submitted to the~~
7 ~~Department of Insurance in compliance with the Insurance Code~~
8 ~~relating to financial solvency, provider accessibility, peer review,~~
9 ~~utilization review, and quality assurance, upon request, if the~~
10 ~~administrative director determines the information is necessary to~~
11 ~~verify that the plan is providing medical treatment to injured~~
12 ~~employees consistent with the intent of this article.~~

13 ~~Disclosure of peer review proceedings and records to the~~
14 ~~administrative director shall not alter the status of the proceedings~~
15 ~~or records as privileged and confidential communications~~
16 ~~pursuant to subdivision (d) of Section 10133 of the Insurance~~
17 ~~Code.~~

18 (5) ~~Demonstrates the capability to provide occupational~~
19 ~~medicine and related disciplines.~~

20 (6) ~~Complies with any other requirement the administrative~~
21 ~~director determines is necessary to provide medical services to~~
22 ~~injured employees consistent with the intent of this article,~~
23 ~~including, but not limited to, a written patient grievance policy.~~

24 (e) ~~If the health care organization is a workers' compensation~~
25 ~~insurer, third-party administrator, or any other entity that the~~
26 ~~administrative director determines meets the requirements of~~
27 ~~Section 4600.6, the administrative director shall certify the~~
28 ~~organization to provide health care pursuant to Section 4600.3 if~~
29 ~~the director finds that it meets the following additional~~
30 ~~requirements:~~

31 (1) ~~Proposes to provide all medical and health care services that~~
32 ~~may be required by this article.~~

33 (2) ~~Provides a program involving cooperative efforts by the~~
34 ~~employees, the employer, and the health plan to promote~~
35 ~~workplace health and safety, consultative and other services, and~~
36 ~~early return to work for injured employees.~~

37 (3) ~~Proposes a timely and accurate method to meet the~~
38 ~~requirements set forth by the administrative director for all carriers~~
39 ~~of workers' compensation coverage to report necessary~~
40 ~~information regarding medical and health care service cost and~~



1 utilization, rates of return to work, average time in medical
2 treatment, and other measures as determined by the administrative
3 director to enable the director to determine the effectiveness of the
4 plan.

5 ~~(4) Agrees to provide the administrative director with~~
6 ~~information, reports, and records relating to provider accessibility,~~
7 ~~peer review, utilization review, quality assurance, advertising,~~
8 ~~disclosure, medical and financial audits, and grievance systems;~~
9 ~~upon request, if the administrative director determines the~~
10 ~~information is necessary to verify that the plan is providing~~
11 ~~medical treatment to injured employees consistent with the intent~~
12 ~~of this article.~~

13 ~~Disclosure of peer review proceedings and records to the~~
14 ~~administrative director shall not alter the status of the proceedings~~
15 ~~or records as privileged and confidential communications~~
16 ~~pursuant to subdivision (d) of Section 10133 of the Insurance~~
17 ~~Code.~~

18 ~~(5) Demonstrates the capability to provide occupational~~
19 ~~medicine and related disciplines.~~

20 ~~(6) Complies with any other requirement the administrative~~
21 ~~director determines is necessary to provide medical services to~~
22 ~~injured employees consistent with the intent of this article,~~
23 ~~including, but not limited to, a written patient grievance policy.~~

24 ~~(7) Complies with the following requirements:~~

25 ~~(A) An organization certified by the administrative director~~
26 ~~under this subdivision may not provide or undertake to arrange for~~
27 ~~the provision of health care to employees, or to pay for or to~~
28 ~~reimburse any part of the cost of that health care in return for a~~
29 ~~prepaid or periodic charge paid by or on behalf of those employees.~~

30 ~~(B) Every organization certified under this subdivision shall~~
31 ~~operate on a fee-for-service basis. As used in this section, fee for~~
32 ~~service refers to the situation where the amount of reimbursement~~
33 ~~paid by the employer to the organization or providers of health care~~
34 ~~is determined by the amount and type of health care rendered by~~
35 ~~the organization or provider of health care.~~

36 ~~(C) An organization certified under this subdivision is~~
37 ~~prohibited from assuming risk.~~

38 ~~(f) (1) A workers' compensation health care provider~~
39 ~~organization authorized by the Department of Corporations on~~



1 ~~December 31, 1997, shall be eligible for certification as a health~~
2 ~~care organization under subdivision (e).~~

3 ~~(2) An entity that had, on December 31, 1997, submitted an~~
4 ~~application with the Commissioner of Corporations under Part 3.2~~
5 ~~(commencing with Section 5150) shall be considered an applicant~~
6 ~~for certification under subdivision (e) and shall be entitled to~~
7 ~~priority in consideration of its application. The Commissioner of~~
8 ~~Corporations shall provide complete files for all pending~~
9 ~~applications to the administrative director on or before January 31,~~
10 ~~1998.~~

11 ~~(g) The provisions of this section shall not affect the~~
12 ~~confidentiality or admission in evidence of a claimant's medical~~
13 ~~treatment records.~~

14 ~~(h) Charges for services arranged for or provided by health care~~
15 ~~service plans certified by this section and that are paid on a~~
16 ~~per-enrollee-periodic-charge basis shall not be subject to the~~
17 ~~schedules adopted by the administrative director pursuant to~~
18 ~~Section 5307.1.~~

19 ~~(i) Nothing in this section shall be construed to expand or~~
20 ~~constrict any requirements imposed by law on a health care service~~
21 ~~plan or insurer when operating as other than a health care~~
22 ~~organization pursuant to this section.~~

23 ~~(j) In consultation with interested parties, including the~~
24 ~~Department of Corporations and the Department of Insurance, the~~
25 ~~administrative director shall adopt rules necessary to carry out this~~
26 ~~section.~~

27 ~~(k) The administrative director shall refuse to certify or may~~
28 ~~revoke or suspend the certification of any health care organization~~
29 ~~under this section if the director finds that:~~

30 ~~(1) The plan for providing medical treatment fails to meet the~~
31 ~~requirements of this section.~~

32 ~~(2) A health care service plan licensed by the Department of~~
33 ~~Managed Health Care, a workers' compensation health care~~
34 ~~provider organization authorized by the Department of~~
35 ~~Corporations, or a carrier licensed by the Department of Insurance~~
36 ~~is not in good standing with its licensing agency.~~

37 ~~(3) Services under the plan are not being provided in~~
38 ~~accordance with the terms of a certified plan.~~

39 ~~(l) (1) When an injured employee requests chiropractic~~
40 ~~treatment for work-related injuries, the health care organization~~



1 shall provide the injured worker with access to the services of a
 2 chiropractor pursuant to guidelines for chiropractic care
 3 established by paragraph (2). Within five working days of the
 4 employee's request to see a chiropractor, the health care
 5 organization and any person or entity who directs the kind or
 6 manner of health care services for the plan shall refer an injured
 7 employee to an affiliated chiropractor for work-related injuries
 8 that are within the guidelines for chiropractic care established by
 9 paragraph (2). Chiropractic care rendered in accordance with
 10 guidelines for chiropractic care established pursuant to paragraph
 11 (2) shall be provided by duly licensed chiropractors affiliated with
 12 the plan.

13 (2) The health care organization shall establish guidelines for
 14 chiropractic care in consultation with affiliated chiropractors who
 15 are participants in the health care organization's utilization review
 16 process for chiropractic care, which may include qualified medical
 17 evaluators knowledgeable in the treatment of chiropractic
 18 conditions. The guidelines for chiropractic care shall, at a
 19 minimum, explicitly require the referral of any injured employee
 20 who so requests to an affiliated chiropractor for the evaluation or
 21 treatment, or both, of neuromusculoskeletal conditions.

22 (3) Whenever a dispute concerning the appropriateness or
 23 necessity of chiropractic care for work-related injuries arises, the
 24 dispute shall be resolved by the health care organization's
 25 utilization review process for chiropractic care in accordance with
 26 the health care organization's guidelines for chiropractic care
 27 established by paragraph (2).

28 Chiropractic utilization review for work-related injuries shall
 29 be conducted in accordance with the health care organization's
 30 approved quality assurance standards and utilization review
 31 process for chiropractic care. Chiropractors affiliated with the plan
 32 shall have access to the health care organization's provider appeals
 33 process and, in the case of chiropractic care for work-related
 34 injuries, the review shall include review by a chiropractor
 35 affiliated with the health care organization, as determined by the
 36 health care organization.

37 (4) The health care organization shall inform employees of the
 38 procedures for processing and resolving grievances, including
 39 those related to chiropractic care, including the location and
 40 telephone number where grievances may be submitted.

[4]



1 ~~(5) All guidelines for chiropractic care and utilization review~~
2 ~~shall be consistent with the standards of this code that require care~~
3 ~~to cure or relieve the effects of the industrial injury.~~

4 ~~(m) Individually identifiable medical information on patients~~
5 ~~submitted to the division shall not be subject to the California~~
6 ~~Public Records Act (Chapter 3.5 (commencing with Section 6250)~~
7 ~~of Division 7 of Title 1 of the Government Code).~~

8 ~~(n) (1) When an injured employee requests acupuncture~~
9 ~~treatment for work-related injuries, the health care organization~~
10 ~~shall provide the injured worker with access to the services of an~~
11 ~~acupuncturist pursuant to guidelines for acupuncture care~~
12 ~~established by paragraph (2). Within five working days of the~~
13 ~~employee's request to see an acupuncturist, the health care~~
14 ~~organization and any person or entity who directs the kind or~~
15 ~~manner of health care services for the plan shall refer an injured~~
16 ~~employee to an affiliated acupuncturist for work-related injuries~~
17 ~~that are within the guidelines for acupuncture care established by~~
18 ~~paragraph (2). Acupuncture care rendered in accordance with~~
19 ~~guidelines for acupuncture care established pursuant to paragraph~~
20 ~~(2) shall be provided by duly licensed acupuncturists affiliated~~
21 ~~with the plan.~~

22 ~~(2) The health care organization shall establish guidelines for~~
23 ~~acupuncture care in consultation with affiliated acupuncturists~~
24 ~~who are participants in the health care organization's utilization~~
25 ~~review process for acupuncture care, which may include qualified~~
26 ~~medical evaluators. The guidelines for acupuncture care shall, at~~
27 ~~a minimum, explicitly require the referral of any injured employee~~
28 ~~who so requests to an affiliated acupuncturist for the evaluation or~~
29 ~~treatment, or both, of neuromusculoskeletal conditions.~~

30 ~~(3) Whenever a dispute concerning the appropriateness or~~
31 ~~necessity of acupuncture care for work-related injuries arises, the~~
32 ~~dispute shall be resolved by the health care organization's~~
33 ~~utilization review process for acupuncture care in accordance with~~
34 ~~the health care organization's guidelines for acupuncture care~~
35 ~~established by paragraph (2).~~

36 ~~Acupuncture utilization review for work-related injuries shall~~
37 ~~be conducted in accordance with the health care organization's~~
38 ~~approved quality assurance standards and utilization review~~
39 ~~process for acupuncture care. Acupuncturists affiliated with the~~
40 ~~plan shall have access to the health care organization's provider~~



1 ~~appeals process and, in the case of acupuncture care for~~
2 ~~work-related injuries, the review shall include review by an~~
3 ~~acupuncturist affiliated with the health care organization, as~~
4 ~~determined by the health care organization.~~

5 ~~(4) The health care organization shall inform employees of the~~
6 ~~procedures for processing and resolving grievances, including~~
7 ~~those related to acupuncture care, including the location and~~
8 ~~telephone number where grievances may be submitted.~~

9 ~~(5) All guidelines for acupuncture care and utilization review~~
10 ~~shall be consistent with the standards of this code that require care~~
11 ~~to cure or relieve the effects of the industrial injury.~~

12 SEC. 21. Section 4600.5 is added to the Labor Code, to read:

13 4600.5. (a) Any health care service plan licensed pursuant to
14 the Knox-Keene Health Care Service Plan Act, a disability insurer
15 licensed by the Department of Insurance, or any entity, including,
16 but not limited to, workers' compensation insurers and third-party
17 administrators authorized by the administrative director under
18 subdivision (e), may make written application to the
19 administrative director to become certified as a health care
20 organization to provide health care to injured employees for
21 injuries and diseases compensable under this article. The
22 administrative director shall establish or process for the timely
23 review of applications.

24 (b) Each application for certification shall be accompanied by
25 a reasonable fee prescribed by the administrative director,
26 sufficient to cover the actual cost of processing the application. A
27 certificate is valid for the period that the administrative director
28 may prescribe unless sooner revoked or suspended.

29 (c) If the health care organization is a health care service plan
30 licensed pursuant to the Knox-Keene Health Care Service Plan
31 Act, and has provided the Managed Care Unit of the Division of
32 Workers' Compensation with the necessary documentation to
33 comply with this subdivision, that organization shall be deemed to
34 be a health care organization able to provide health care pursuant
35 to Section 4600.3, without further application duplicating the
36 documentation already filed with the Department of Managed
37 Health Care. These plans shall be required to remain in good
38 standing with the Department of Managed Health Care, and shall
39 meet all of the requirements the administrative director deems
40 necessary.



1 (d) If the health care organization is a disability insurer licensed
2 by the Department of Insurance, and is in compliance with
3 subdivision (d) of Sections 10133 and 10133.5 of the Insurance
4 Code, the administrative director shall certify the organization to
5 provide health care pursuant to Section 4600.3 if the
6 administrative director finds that the plan is in good standing with
7 the Department of Insurance and meets all of the requirements the
8 administrative director deems necessary.

9 (e) If the health care organization is a workers' compensation
10 insurer, third-party administrator, or any other entity that the
11 administrative director determines meets the requirements of
12 Section 4600.6, the administrative director shall certify the
13 organization to provide health care pursuant to this article.

14 (f) Charges for services arranged for or provided by health care
15 service plans certified by this section and that are paid on a
16 per-enrollee-periodic-charge basis shall not be subject to the
17 schedules adopted by the administrative director pursuant to
18 Section 5307.1.

19 (g) Nothing in this section shall be construed to expand or
20 constrict any requirements imposed by law on a health care service
21 plan or insurer when operating as other than a health care
22 organization pursuant to this section.

23 (h) In consultation with interested parties, including the
24 Department of Corporations and the Department of Insurance, the
25 administrative director shall adopt rules necessary to carry out this
26 section.

27 (i) The administrative director shall refuse to certify or may
28 revoke or suspend the certification of any health care organization
29 under this section if the director finds that any of the following
30 circumstances exist:

31 (1) The plan for providing medical treatment fails to meet the
32 requirements of this section.

33 (2) A health care service plan licensed by the Department of
34 Managed Health Care, a workers' compensation health care
35 provider organization authorized by the Department of
36 Corporations, or a carrier licensed by the Department of Insurance
37 is not in good standing with its licensing agency.

38 (3) Services under the plan are not being provided in
39 accordance with the terms of a certified plan.



1 (j) When an injured employee requests chiropractic treatment
2 for work-related injuries, the health care organization shall
3 provide the injured worker with access to the services of a
4 chiropractor. Chiropractic care rendered in accordance with
5 guidelines for chiropractic care shall be provided by duly licensed
6 chiropractors affiliated with the plan.

7 (k) When an injured employee requests acupuncture treatment
8 for what the treating physician agrees are work-related injuries, the
9 health care organization shall provide the injured worker with
10 access to the services of an acupuncturist. Acupuncture care
11 rendered in accordance with guidelines for acupuncture care shall
12 be provided by duly licensed acupuncturists affiliated with the
13 plan.

14 SEC. 22. Section 4600.6 of the Labor Code is repealed.

15 ~~4600.6. Any workers' compensation insurer, third-party
16 administrator, or other entity seeking certification as a health care
17 organization under subdivision (e) of Section 4600.5 shall be
18 subject to the following rules and procedures:~~

19 ~~(a) Each application for authorization as an organization under
20 subdivision (e) of Section 4600.5 shall be verified by an authorized
21 representative of the applicant and shall be in a form prescribed by
22 the administrative director. The application shall be accompanied
23 by the prescribed fee and shall set forth or be accompanied by each
24 and all of the following:~~

25 ~~(1) The basic organizational documents of the applicant, such
26 as the articles of incorporation, articles of association, partnership
27 agreement, trust agreement, or other applicable documents and all
28 amendments thereto.~~

29 ~~(2) A copy of the bylaws, rules, and regulations, or similar
30 documents regulating the conduct of the internal affairs of the
31 applicant.~~

32 ~~(3) A list of the names, addresses, and official positions of the
33 persons who are to be responsible for the conduct of the affairs of
34 the applicant, which shall include, among others, all members of
35 the board of directors, board of trustees, executive committee, or
36 other governing board or committee, the principal officers, each
37 shareholder with over 5 percent interest in the case of a
38 corporation, and all partners or members in the case of a
39 partnership or association, and each person who has loaned funds
40 to the applicant for the operation of its business.~~

[4]



1 ~~(4) A copy of any contract made, or to be made, between the~~
2 ~~applicant and any provider of health care, or persons listed in~~
3 ~~paragraph (3), or any other person or organization agreeing to~~
4 ~~perform an administrative function or service for the plan. The~~
5 ~~administrative director by rule may identify contracts excluded~~
6 ~~from this requirement and make provision for the submission of~~
7 ~~form contracts. The payment rendered or to be rendered to the~~
8 ~~provider of health care services shall be deemed confidential~~
9 ~~information that shall not be divulged by the administrative~~
10 ~~director, except that the payment may be disclosed and become a~~
11 ~~public record in any legislative, administrative, or judicial~~
12 ~~proceeding or inquiry. The organization shall also submit the name~~
13 ~~and address of each provider employed by, or contracting with, the~~
14 ~~organization, together with his or her license number.~~

15 ~~(5) A statement describing the organization, its method of~~
16 ~~providing for health services, and its physical facilities. If~~
17 ~~applicable, this statement shall include the health care delivery~~
18 ~~capabilities of the organization, including the number of full-time~~
19 ~~and part-time physicians under Section 3209.3, the numbers and~~
20 ~~types of licensed or state-certified health care support staff, the~~
21 ~~number of hospital beds contracted for, and the arrangements and~~
22 ~~the methods by which health care will be provided, as defined by~~
23 ~~the administrative director under Sections 4600.3 and 4600.5.~~

24 ~~(6) A copy of the disclosure forms or materials that are to be~~
25 ~~issued to employees.~~

26 ~~(7) A copy of the form of the contract that is to be issued to any~~
27 ~~employer, insurer of an employer, or a group of self-insured~~
28 ~~employers.~~

29 ~~(8) Financial statements accompanied by a report, certificate,~~
30 ~~or opinion of an independent certified public accountant.~~
31 ~~However, the financial statements from public entities or political~~
32 ~~subdivisions of the state need not include a report, certificate, or~~
33 ~~opinion by an independent certified public accountant if the~~
34 ~~financial statement complies with any requirements that may be~~
35 ~~established by regulation of the administrative director.~~

36 ~~(9) A description of the proposed method of marketing the~~
37 ~~organization and a copy of any contract made with any person to~~
38 ~~solicit on behalf of the organization or a copy of the form of~~
39 ~~agreement used and a list of the contracting parties.~~



1 ~~(10) A statement describing the service area or areas to be~~
2 ~~served, including the service location for each provider rendering~~
3 ~~professional services on behalf of the organization and the location~~
4 ~~of any other organization facilities where required by the~~
5 ~~administrative director.~~

6 ~~(11) A description of organization grievance procedures to be~~
7 ~~utilized as required by this part, and a copy of the form specified~~
8 ~~by paragraph (3) of subdivision (j).~~

9 ~~(12) A description of the procedures and programs for internal~~
10 ~~review of the quality of health care pursuant to the requirements~~
11 ~~set forth in this part.~~

12 ~~(13) Evidence of adequate insurance coverage or~~
13 ~~self-insurance to respond to claims for damages arising out of the~~
14 ~~furnishing of workers' compensation health care.~~

15 ~~(14) Evidence of adequate insurance coverage or~~
16 ~~self-insurance to protect against losses of facilities where required~~
17 ~~by the administrative director.~~

18 ~~(15) Evidence of adequate workers' compensation coverage to~~
19 ~~protect against claims arising out of work-related injuries that~~
20 ~~might be brought by the employees and staff of an organization~~
21 ~~against the organization.~~

22 ~~(16) Evidence of fidelity bonds in such amount as the~~
23 ~~administrative director prescribes by regulation.~~

24 ~~(17) Other information that the administrative director may~~
25 ~~reasonably require.~~

26 ~~(b) (1) An organization, solicitor, solicitor firm, or~~
27 ~~representative may not use or permit the use of any advertising or~~
28 ~~solicitation that is untrue or misleading, or any form of disclosure~~
29 ~~that is deceptive. For purposes of this chapter:~~

30 ~~(A) A written or printed statement or item of information shall~~
31 ~~be deemed untrue if it does not conform to fact in any respect that~~
32 ~~is or may be significant to an employer or employee, or potential~~
33 ~~employer or employee.~~

34 ~~(B) A written or printed statement or item of information shall~~
35 ~~be deemed misleading whether or not it may be literally true, if,~~
36 ~~in the total context in which the statement is made or the item of~~
37 ~~information is communicated, the statement or item of~~
38 ~~information may be understood by a person not possessing special~~
39 ~~knowledge regarding health care coverage, as indicating any~~
40 ~~benefit or advantage, or the absence of any exclusion, limitation,~~



1 or disadvantage of possible significance to an employer or
2 employee, or potential employer or employee.

3 ~~(C) A disclosure form shall be deemed to be deceptive if the~~
4 ~~disclosure form taken as a whole and with consideration given to~~
5 ~~typography and format, as well as language, shall be such as to~~
6 ~~cause a reasonable person, not possessing special knowledge of~~
7 ~~workers' compensation health care, and the disclosure form~~
8 ~~therefor, to expect benefits, service charges, or other advantages~~
9 ~~that the disclosure form does not provide or that the organization~~
10 ~~issuing that disclosure form does not regularly make available to~~
11 ~~employees.~~

12 ~~(2) An organization, solicitor, or representative may not use or~~
13 ~~permit the use of any verbal statement that is untrue, misleading,~~
14 ~~or deceptive or make any representations about health care offered~~
15 ~~by the organization or its cost that does not conform to fact. All~~
16 ~~verbal statements are to be held to the same standards as those for~~
17 ~~printed matter provided in paragraph (1).~~

18 ~~(e) It is unlawful for any person, including an organization,~~
19 ~~subject to this part, to represent or imply in any manner that the~~
20 ~~person or organization has been sponsored, recommended, or~~
21 ~~approved, or that the person's or organization's abilities or~~
22 ~~qualifications have in any respect been passed upon, by the~~
23 ~~administrative director.~~

24 ~~(d) (1) An organization may not publish or distribute, or allow~~
25 ~~to be published or distributed on its behalf, any advertisement~~
26 ~~unless (A) a true copy thereof has first been filed with the~~
27 ~~administrative director, at least 30 days prior to any such use, or~~
28 ~~any shorter period as the administrative director by rule or order~~
29 ~~may allow, and (B) the administrative director by notice has not~~
30 ~~found the advertisement, wholly or in part, to be untrue,~~
31 ~~misleading, deceptive, or otherwise not in compliance with this~~
32 ~~part or the rules thereunder, and specified the deficiencies, within~~
33 ~~the 30 days or any shorter time as the administrative director by~~
34 ~~rule or order may allow.~~

35 ~~(2) If the administrative director finds that any advertisement~~
36 ~~of an organization has materially failed to comply with this part or~~
37 ~~the rules thereunder, the administrative director may, by order,~~
38 ~~require the organization to publish in the same or similar medium,~~
39 ~~an approved correction or retraction of any untrue, misleading, or~~
40 ~~deceptive statement contained in the advertising.~~



1 ~~(3) The administrative director by rule or order may classify~~
2 ~~organizations and advertisements and exempt certain classes,~~
3 ~~wholly or in part, either unconditionally or upon specified terms~~
4 ~~and conditions or for specified periods, from the application of~~
5 ~~subdivision (a).~~

6 ~~(e) (1) The administrative director shall require the use by~~
7 ~~each organization of disclosure forms or materials containing any~~
8 ~~information regarding the health care and terms of the workers'~~
9 ~~compensation health care contract that the administrative director~~
10 ~~may require, so as to afford the public, employers, and employees~~
11 ~~with a full and fair disclosure of the provisions of the contract in~~
12 ~~readily understood language and in a clearly organized manner.~~
13 ~~The administrative director may require that the materials be~~
14 ~~presented in a reasonably uniform manner so as to facilitate~~
15 ~~comparisons between contracts of the same or other types of~~
16 ~~organizations. The disclosure form shall describe the health care~~
17 ~~that is required by the administrative director under Sections~~
18 ~~4600.3 and 4600.5, and shall provide that all information be in~~
19 ~~concise and specific terms, relative to the contract, together with~~
20 ~~any additional information as may be required by the~~
21 ~~administrative director, in connection with the organization or~~
22 ~~contract.~~

23 ~~(2) All organizations, solicitors, and representatives of a~~
24 ~~workers' compensation health care provider organization shall,~~
25 ~~when presenting any contract for examination or sale to a~~
26 ~~prospective employee, provide the employee with a properly~~
27 ~~completed disclosure form, as prescribed by the administrative~~
28 ~~director pursuant to this section for each contract so examined or~~
29 ~~sold.~~

30 ~~(3) In addition to the other disclosures required by this section,~~
31 ~~every organization and any agent or employee of the organization~~
32 ~~shall, when representing an organization for examination or sale~~
33 ~~to any individual purchaser or the representative of a group~~
34 ~~consisting of 25 or fewer individuals, disclose in writing the ratio~~
35 ~~of premium cost to health care paid for contracts with individuals~~
36 ~~and with groups of the same or similar size for the organization's~~
37 ~~preceding fiscal year. An organization may report that information~~
38 ~~by geographic area, provided the organization identifies the~~
39 ~~geographic area and reports information applicable to that~~
40 ~~geographic area.~~



1 ~~(4) Where the administrative director finds it necessary in the~~
2 ~~interest of full and fair disclosure, all advertising and other~~
3 ~~consumer information disseminated by an organization for the~~
4 ~~purpose of influencing persons to become members of an~~
5 ~~organization shall contain any supplemental disclosure~~
6 ~~information that the administrative director may require.~~

7 ~~(f) When the administrative director finds it necessary in the~~
8 ~~interest of full and fair disclosure, all advertising and other~~
9 ~~consumer information disseminated by an organization for the~~
10 ~~purpose of influencing persons to become members of an~~
11 ~~organization shall contain any supplemental disclosure~~
12 ~~information that the administrative director may require.~~

13 ~~(g) (1) An organization may not refuse to enter into any~~
14 ~~contract or may not cancel or decline to renew or reinstate any~~
15 ~~contract because of the race, color, national origin, ancestry,~~
16 ~~religion, sex, marital status, sexual orientation, or age of any~~
17 ~~contracting party, prospective contracting party, or person~~
18 ~~reasonably expected to benefit from that contract as an employee~~
19 ~~or otherwise.~~

20 ~~(2) The terms of any contract shall not be modified, and the~~
21 ~~benefits or coverage of any contract shall not be subject to any~~
22 ~~limitations, exceptions, exclusions, reductions, copayments,~~
23 ~~coinsurance, deductibles, reservations, or premium, price, or~~
24 ~~charge differentials, or other modifications because of the race,~~
25 ~~color, national origin, ancestry, religion, sex, marital status, sexual~~
26 ~~orientation, or age of any contracting party, potential contracting~~
27 ~~party, or person reasonably expected to benefit from that contract~~
28 ~~as an employee or otherwise; except that premium, price, or charge~~
29 ~~differentials because of the sex or age of any individual when~~
30 ~~based on objective, valid, and up-to-date statistical and actuarial~~
31 ~~data are not prohibited. Nothing in this section shall be construed~~
32 ~~to permit an organization to charge different rates to individual~~
33 ~~employees within the same group solely on the basis of the~~
34 ~~employee's sex.~~

35 ~~(3) It shall be deemed a violation of subdivision (a) for any~~
36 ~~organization to utilize marital status, living arrangements,~~
37 ~~occupation, gender, beneficiary designation, ZIP Codes or other~~
38 ~~territorial classification, or any combination thereof for the~~
39 ~~purpose of establishing sexual orientation. Nothing in this section~~
40 ~~shall be construed to alter in any manner the existing law~~



1 ~~prohibiting organizations from conducting tests for the presence~~
2 ~~of human immunodeficiency virus or evidence thereof.~~

3 ~~(4) This section shall not be construed to limit the authority of~~
4 ~~the administrative director to adopt or enforce regulations~~
5 ~~prohibiting discrimination because of sex, marital status, or sexual~~
6 ~~orientation.~~

7 ~~(h) (1) An organization may not use in its name any of the~~
8 ~~words “insurance,” “casualty,” “health care service plan,”~~
9 ~~“health plan,” “surety,” “mutual,” or any other words~~
10 ~~descriptive of the health plan, insurance, casualty, or surety~~
11 ~~business or use any name similar to the name or description of any~~
12 ~~health care service plan, insurance, or surety corporation doing~~
13 ~~business in this state unless that organization controls or is~~
14 ~~controlled by an entity licensed as a health care service plan or~~
15 ~~insurer pursuant to the Health and Safety Code or the Insurance~~
16 ~~Code and the organization employs a name related to that of the~~
17 ~~controlled or controlling entity.~~

18 ~~(2) Section 2415 of the Business and Professions Code,~~
19 ~~pertaining to fictitious names, does not apply to organizations~~
20 ~~certified under this section.~~

21 ~~(3) An organization or solicitor firm may not adopt a name style~~
22 ~~that is deceptive, or one that could cause the public to believe the~~
23 ~~organization is affiliated with or recommended by any~~
24 ~~governmental or private entity unless this affiliation or~~
25 ~~endorsement exists.~~

26 ~~(i) Each organization shall meet the following requirements:~~

27 ~~(1) All facilities located in this state, including, but not limited~~
28 ~~to, clinics, hospitals, and skilled nursing facilities, to be utilized by~~
29 ~~the organization shall be licensed by the State Department of~~
30 ~~Health Services, if that licensure is required by law. Facilities not~~
31 ~~located in this state shall conform to all licensing and other~~
32 ~~requirements of the jurisdiction in which they are located.~~

33 ~~(2) All personnel employed by or under contract to the~~
34 ~~organization shall be licensed or certified by their respective board~~
35 ~~or agency, where that licensure or certification is required by law.~~

36 ~~(3) All equipment required to be licensed or registered by law~~
37 ~~shall be so licensed or registered and the operating personnel for~~
38 ~~that equipment shall be licensed or certified as required by law.~~

39 ~~(4) The organization shall furnish services in a manner~~
40 ~~providing continuity of care and ready referral of patients to other~~



1 providers at any time as may be appropriate and consistent with
2 good professional practice.

3 (5) All health care shall be readily available at reasonable times
4 to all employees. To the extent feasible, the organization shall
5 make all health care readily accessible to all employees.

6 (6) The organization shall employ and utilize allied health
7 manpower for the furnishing of health care to the extent permitted
8 by law and consistent with good health care practice.

9 (7) The organization shall have the organizational and
10 administrative capacity to provide services to employees. The
11 organization shall be able to demonstrate to the department that
12 health care decisions are rendered by qualified providers,
13 unhindered by fiscal and administrative management.

14 (8) All contracts with employers, insurers of employers, and
15 self-insured employers and all contracts with providers, and other
16 persons furnishing services, equipment, or facilities to or in
17 connection with the workers' compensation health care
18 organization, shall be fair, reasonable, and consistent with the
19 objectives of this part.

20 (9) Each organization shall provide to employees all workers'
21 compensation health care required by this code. The
22 administrative director shall not determine the scope of workers'
23 compensation health care to be offered by an organization.

24 (j) (1) Every organization shall establish and maintain a
25 grievance system approved by the administrative director under
26 which employees may submit their grievances to the organization.
27 Each system shall provide reasonable procedures in accordance
28 with regulations adopted by the administrative director that shall
29 ensure adequate consideration of employee grievances and
30 rectification when appropriate.

31 (2) Every organization shall inform employees upon
32 enrollment and annually thereafter of the procedures for
33 processing and resolving grievances. The information shall
34 include the location and telephone number where grievances may
35 be submitted.

36 (3) Every organization shall provide forms for complaints to be
37 given to employees who wish to register written complaints. The
38 forms used by organizations shall be approved by the
39 administrative director in advance as to format.



1 ~~(4) The organization shall keep in its files all copies of~~
2 ~~complaints, and the responses thereto, for a period of five years.~~

3 ~~(k) Every organization shall establish procedures in~~
4 ~~accordance with regulations of the administrative director for~~
5 ~~continuously reviewing the quality of care, performance of~~
6 ~~medical personnel, utilization of services and facilities, and costs.~~
7 ~~Notwithstanding any other provision of law, there shall be no~~
8 ~~monetary liability on the part of, and no cause of action for~~
9 ~~damages shall arise against, any person who participates in quality~~
10 ~~of care or utilization reviews by peer review committees that are~~
11 ~~composed chiefly of physicians, as defined by Section 3209.3, for~~
12 ~~any act performed during the reviews if the person acts without~~
13 ~~malice, has made a reasonable effort to obtain the facts of the~~
14 ~~matter, and believes that the action taken is warranted by the facts,~~
15 ~~and neither the proceedings nor the records of the reviews shall be~~
16 ~~subject to discovery, nor shall any person in attendance at the~~
17 ~~reviews be required to testify as to what transpired thereat.~~
18 ~~Disclosure of the proceedings or records to the governing body of~~
19 ~~an organization or to any person or entity designated by the~~
20 ~~organization to review activities of the committees shall not alter~~
21 ~~the status of the records or of the proceedings as privileged~~
22 ~~communications.~~

23 ~~The above prohibition relating to discovery or testimony does~~
24 ~~not apply to the statements made by any person in attendance at a~~
25 ~~review who is a party to an action or proceeding the subject matter~~
26 ~~of which was reviewed, or to any person requesting hospital staff~~
27 ~~privileges, or in any action against an insurance carrier alleging~~
28 ~~bad faith by the carrier in refusing to accept a settlement offer~~
29 ~~within the policy limits, or to the administrative director in~~
30 ~~conducting surveys pursuant to subdivision (o).~~

31 ~~This section shall not be construed to confer immunity from~~
32 ~~liability on any workers' compensation health care organization.~~
33 ~~In any case in which, but for the enactment of the preceding~~
34 ~~provisions of this section, a cause of action would arise against an~~
35 ~~organization, the cause of action shall exist notwithstanding the~~
36 ~~provisions of this section.~~

37 ~~(l) Nothing in this chapter shall be construed to prevent an~~
38 ~~organization from utilizing subcommittees to participate in peer~~
39 ~~review activities, nor to prevent an organization from delegating~~
40 ~~the responsibilities required by subdivision (i) as it determines to~~



1 ~~be appropriate, to subcommittees including subcommittees~~
2 ~~composed of a majority of nonphysician health care providers~~
3 ~~licensed pursuant to the Business and Professions Code, as long as~~
4 ~~the organization controls the scope of authority delegated and may~~
5 ~~revoke all or part of this authority at any time. Persons who~~
6 ~~participate in the subcommittees shall be entitled to the same~~
7 ~~immunity from monetary liability and actions for civil damages as~~
8 ~~persons who participate in organization or provider peer review~~
9 ~~committees pursuant to subdivision (i):~~

10 ~~(m) Every organization shall have and shall demonstrate to the~~
11 ~~administrative director that it has all of the following:~~

12 ~~(1) Adequate provision for continuity of care.~~

13 ~~(2) A procedure for prompt payment and denial of provider~~
14 ~~claims.~~

15 ~~(n) Every contract between an organization and an employer or~~
16 ~~insurer of an employer, and every contract between any~~
17 ~~organization and a provider of health care, shall be in writing.~~

18 ~~(o) (1) The administrative director shall conduct periodically~~
19 ~~an onsite medical survey of the health care delivery system of each~~
20 ~~organization. The survey shall include a review of the procedures~~
21 ~~for obtaining health care, the procedures for regulating utilization,~~
22 ~~peer review mechanisms, internal procedures for assuring quality~~
23 ~~of care, and the overall performance of the organization in~~
24 ~~providing health care and meeting the health needs of employees.~~

25 ~~(2) The survey shall be conducted by a panel of qualified health~~
26 ~~professionals experienced in evaluating the delivery of workers'~~
27 ~~compensation health care. The administrative director shall be~~
28 ~~authorized to contract with professional organizations or outside~~
29 ~~personnel to conduct medical surveys. These organizations or~~
30 ~~personnel shall have demonstrated the ability to objectively~~
31 ~~evaluate the delivery of this health care.~~

32 ~~(3) Surveys performed pursuant to this section shall be~~
33 ~~conducted as often as deemed necessary by the administrative~~
34 ~~director to assure the protection of employees, but not less~~
35 ~~frequently than once every three years. Nothing in this section~~
36 ~~shall be construed to require the survey team to visit each clinic,~~
37 ~~hospital, office, or facility of the organization.~~

38 ~~(4) Nothing in this section shall be construed to require the~~
39 ~~medical survey team to review peer review proceedings and~~
40 ~~records conducted and compiled under this section or in medical~~



1 records. However, the administrative director shall be authorized
2 to require onsite review of these peer review proceedings and
3 records or medical records where necessary to determine that
4 quality health care is being delivered to employees. Where
5 medical record review is authorized, the survey team shall ensure
6 that the confidentiality of the physician-patient relationship is
7 safeguarded in accordance with existing law and neither the survey
8 team nor the administrative director or the administrative
9 director's staff may be compelled to disclose this information
10 except in accordance with the physician-patient relationship. The
11 administrative director shall ensure that the confidentiality of the
12 peer review proceedings and records is maintained. The disclosure
13 of the peer review proceedings and records to the administrative
14 director or the medical survey team shall not alter the status of the
15 proceedings or records as privileged and confidential
16 communications.

17 (5) The procedures and standards utilized by the survey team
18 shall be made available to the organizations prior to the conducting
19 of medical surveys.

20 (6) During the survey, the members of the survey team shall
21 offer such advice and assistance to the organization as deemed
22 appropriate.

23 (7) The administrative director shall notify the organization of
24 deficiencies found by the survey team. The administrative director
25 shall give the organization a reasonable time to correct the
26 deficiencies, and failure on the part of the organization to comply
27 to the administrative director's satisfaction shall constitute cause
28 for disciplinary action against the organization.

29 (8) Reports of all surveys, deficiencies, and correction plans
30 shall be open to public inspection, except that no surveys,
31 deficiencies or correction plans shall be made public unless the
32 organization has had an opportunity to review the survey and file
33 a statement of response within 30 days, to be attached to the report.

34 (p) (1) All records, books, and papers of an organization,
35 management company, solicitor, solicitor firm, and any provider
36 or subcontractor providing medical or other services to an
37 organization, management company, solicitor, or solicitor firm
38 shall be open to inspection during normal business hours by the
39 administrative director.



1 ~~(2) To the extent feasible, all the records, books, and papers~~
2 ~~described in paragraph (1) shall be located in this state. In~~
3 ~~examining those records outside this state, the administrative~~
4 ~~director shall consider the cost to the organization, consistent with~~
5 ~~the effectiveness of the administrative director's examination, and~~
6 ~~may upon reasonable notice require that these records, books, and~~
7 ~~papers, or a specified portion thereof, be made available for~~
8 ~~examination in this state, or that a true and accurate copy of these~~
9 ~~records, books, and papers, or a specified portion thereof, be~~
10 ~~furnished to the administrative director.~~

11 ~~(q) (1) The administrative director shall conduct an~~
12 ~~examination of the administrative affairs of any organization, and~~
13 ~~each person with whom the organization has made arrangements~~
14 ~~for administrative, or management services, as often as deemed~~
15 ~~necessary to protect the interest of employees, but not less~~
16 ~~frequently than once every five years.~~

17 ~~(2) The expense of conducting any additional or nonroutine~~
18 ~~examinations pursuant to this section, and the expense of~~
19 ~~conducting any additional or nonroutine medical surveys pursuant~~
20 ~~to subdivision (o) shall be charged against the organization being~~
21 ~~examined or surveyed. The amount shall include the actual salaries~~
22 ~~or compensation paid to the persons making the examination or~~
23 ~~survey, the expenses incurred in the course thereof, and overhead~~
24 ~~costs in connection therewith as fixed by the administrative~~
25 ~~director. In determining the cost of examinations or surveys, the~~
26 ~~administrative director may use the estimated average hourly cost~~
27 ~~for all persons performing examinations or surveys of workers'~~
28 ~~compensation health care organizations for the fiscal year. The~~
29 ~~amount charged shall be remitted by the organization to the~~
30 ~~administrative director.~~

31 ~~(3) Reports of all examinations shall be open to public~~
32 ~~inspection, except that no examination shall be made public,~~
33 ~~unless the organization has had an opportunity to review the~~
34 ~~examination report and file a statement or response within 30 days,~~
35 ~~to be attached to the report.~~

36 SEC. 23. Section 4600.7 of the Labor Code is amended to
37 read:

38 4600.7. ~~(a)~~The Workers' Compensation Managed Care
39 Fund is hereby created in the State Treasury for the administration
40 of Sections 4600.3 and 4600.5 by the Division of Workers'



1 Compensation. The administrative director shall establish a
2 schedule of fees and revenues to be charged to certified health care
3 organizations and applicants for certification to fully fund the
4 administration of these provisions and to repay amounts received
5 as a loan from the General Fund. All fees and revenues shall be
6 deposited in the Workers' Compensation Managed Care Fund and
7 shall be used when appropriated by the Legislature solely for the
8 purpose of carrying out the responsibilities of the Division of
9 Workers' Compensation under Section 4600.3 or 4600.5.

10 ~~(b) On and after July 1, 1998, no funds received as a loan from~~
11 ~~the General Fund shall be used to support the administration of~~
12 ~~Sections 4600.3 and 4600.5. The loan amount shall be repaid to the~~
13 ~~General Fund by assessing a surcharge on the enrollment fee for~~
14 ~~each of the next five fiscal years. In the event the surcharge does~~
15 ~~not produce sufficient revenue over this period, the surcharge shall~~
16 ~~be adjusted to fully repay the loan over the following three fiscal~~
17 ~~years, with the final assessment calculated by dividing the balance~~
18 ~~of the loan by the enrollees at the end of the final fiscal year.~~

19 SEC. 24. Section 4601 of the Labor Code is repealed.

20 ~~4601. (a) If the employee so requests, the employer shall~~
21 ~~tender the employee one change of physician. The employee at any~~
22 ~~time may request that the employer tender this one-time change of~~
23 ~~physician. Upon request of the employee for a change of~~
24 ~~physician, the maximum amount of time permitted by law for the~~
25 ~~employer or insurance carrier to provide the employee an~~
26 ~~alternative physician or, if requested by the employee, a~~
27 ~~chiropractor, or an acupuncturist shall be five working days from~~
28 ~~the date of the request. Notwithstanding the 30-day time period~~
29 ~~specified in Section 4600, a request for a change of physician~~
30 ~~pursuant to this section may be made at any time. The employee~~
31 ~~is entitled, in any serious case, upon request, to the services of a~~
32 ~~consulting physician, chiropractor, or acupuncturist of his or her~~
33 ~~choice at the expense of the employer. The treatment shall be at the~~
34 ~~expense of the employer.~~

35 ~~(b) If an employee requesting a change of physician pursuant~~
36 ~~to subdivision (a) has notified his or her employer in writing prior~~
37 ~~to the date of injury that he or she has a personal chiropractor, the~~
38 ~~alternative physician tendered by the employer to the employee,~~
39 ~~if the employee so requests, shall be the employee's personal~~
40 ~~chiropractor. For the purpose of this article, "personal~~



1 chiropractor” means the employee’s regular chiropractor licensed
2 pursuant to Chapter 2 (commencing with Section 1000) of
3 Division 2 of the Business and Professions Code, who has
4 previously directed treatment of the employee, and who retains the
5 employee’s chiropractic treatment records, including his or her
6 chiropractic history.

7 ~~(c) If an employee requesting a change of physician pursuant~~
8 ~~to subdivision (a) has notified his or her employer in writing prior~~
9 ~~to the date of injury that he or she has a personal acupuncturist, the~~
10 ~~alternative physician tendered by the employer to the employee,~~
11 ~~if the employee so requests, shall be the employee’s personal~~
12 ~~acupuncturist. For the purpose of this article, “personal~~
13 ~~acupuncturist” means the employee’s regular acupuncturist~~
14 ~~licensed pursuant to Chapter 12 (commencing with Section 4935)~~
15 ~~of Division 2 of the Business and Professions Code, who has~~
16 ~~previously directed treatment of the employee, and who retains the~~
17 ~~employee’s acupuncture treatment records, including his or her~~
18 ~~acupuncture history.~~

19 SEC. 25. Section 4602 of the Labor Code is repealed.

20 ~~4602.—If the employee so requests, the employer shall procure~~
21 ~~certification by either the administrative director or the appeals~~
22 ~~board as the case may be of the competency, for the particular case,~~
23 ~~of the consulting or additional physicians.~~

24 SEC. 26. Section 4603 of the Labor Code is repealed.

25 ~~4603.—If the employer desires a change of physicians or~~
26 ~~chiropractor, he may petition the administrative director who,~~
27 ~~upon a showing of good cause by the employer, may order the~~
28 ~~employer to provide a panel of five physicians, or if requested by~~
29 ~~the employee, four physicians and one chiropractor competent to~~
30 ~~treat the particular case, from which the employee must select one.~~

31 SEC. 27. Section 4603.2 of the Labor Code is amended to
32 read:

33 4603.2. (a) Upon selecting a physician pursuant to Section
34 4600, the employee or physician shall forthwith notify the
35 employer of the name and address of the physician. The physician
36 shall submit a report to the employer within five working days
37 from the date of the initial examination and shall submit periodic
38 reports at intervals that may be prescribed by rules and regulations
39 adopted by the administrative director.



1 (b) Payment for medical treatment provided or authorized by
2 the treating physician selected by the employee or designated by
3 the employer shall be made by the employer within 60 days after
4 receipt of each separate, itemized billing, together with any
5 required reports and any written authorization for services that
6 may have been received by the physician. If the billing or a portion
7 thereof is contested, denied, or considered incomplete, the
8 physician shall be notified, in writing, that the billing is contested,
9 denied, or considered incomplete, within 30 working days after
10 receipt of the billing by the employer. A notice that a billing is
11 incomplete shall state all additional information required to make
12 a decision. Any properly documented amount not paid within the
13 60-day period shall be increased by 10 percent, together with
14 interest at the same rate as judgments in civil actions retroactive
15 to the date of receipt of the bill, unless the employer does both of
16 the following:

17 (1) Pays the uncontested amount within the 60-day period.

18 (2) Advises, in the manner prescribed by the administrative
19 director, the physician, or another provider of the items being
20 contested, the reasons for contesting these items, and the remedies
21 available to the physician or the other provider if he or she
22 disagrees. In the case of a bill ~~which~~ *that* includes charges from a
23 hospital, outpatient surgery center, or independent diagnostic
24 facility, advice that a request has been made for an audit of the bill
25 shall satisfy the requirements of this paragraph.

26 If an employer contests all or part of a billing, any amount
27 determined payable by the appeals board shall carry interest from
28 the date the amount was due until it is paid.

29 An employer's liability to a physician or another provider under
30 this section for delayed payments shall not affect its liability to an
31 employee under Section 5814 or any other provision of this
32 division.

33 (c) Any interest or increase in compensation paid by an insurer
34 pursuant to this section shall be treated in the same manner as an
35 increase in compensation under subdivision (d) of Section 4650
36 for the purposes of any classification of risks and premium rates,
37 and any system of merit rating approved or issued pursuant to
38 Article 2 (commencing with Section 11730) of Chapter 3 of Part
39 3 of Division 2 of the Insurance Code.



1 (d) (1) Whenever an employer or insurer employs an
2 individual or contracts with an entity to conduct a review of a
3 billing submitted by a physician or medical provider, the employer
4 or insurer shall make available to that individual or entity all
5 documentation submitted together with that billing by the
6 physician or medical provider. When an individual or entity
7 conducting a bill review determines that additional information or
8 documentation is necessary to review the billing, the individual or
9 entity shall contact the claims administrator or insurer to obtain the
10 necessary information or documentation that was submitted by the
11 physician or medical provider pursuant to subdivision (b).

12 (2) An individual or entity reviewing a bill submitted by a
13 physician or medical provider shall not alter the procedure codes
14 billed or recommend reduction of the amount of the bill unless the
15 documentation submitted by the physician or medical provider
16 with the bill has been reviewed by that individual or entity. If the
17 reviewer does not recommend payment as billed by the physician
18 or medical provider, the explanation of review shall provide the
19 physician or medical provider with a specific explanation as to
20 why the reviewer altered the procedure code or amount billed and
21 the specific deficiency in the billing or documentation that caused
22 the reviewer to conclude that the altered procedure code or amount
23 recommended for payment more accurately represents the service
24 performed.

25 (3) Unless the physician or medical provider has billed for
26 extraordinary circumstances related to the unusual nature of the
27 medical services rendered pursuant to subdivision (b) of Section
28 5307.1, this subdivision shall not apply when a bill submitted by
29 a physician or medical provider is reduced to the amount or
30 amounts specified in the Official Medical Fee Schedule, preferred
31 provider contract, or negotiated rate for the procedure codes billed.

32 (4) The appeals board shall have jurisdiction over disputes
33 arising out of this subdivision pursuant to Section 5304.

34 (e) *This section shall not apply to employees and employers to*
35 *whom Section 4600.3 or 4600.31 applies.*

36 SEC. 28. Section 4604 of the Labor Code is amended to read:
37 4604. Controversies between *an* employer and employee
38 arising under this chapter shall be determined by the appeals board,
39 upon the request of either party. *For those employees and*
40 *employers to whom Section 4600.3 or 4600.31 applies,*



1 *controversies arising under this article shall be determined*
2 *pursuant to the contract.*

3 SEC. 29. Section 4604.5 is added to the Labor Code, to read:

4 4604.5. (a) Upon adoption by the administrative director of
5 a medical treatment utilization schedule pursuant to Section
6 5307.27, the recommended guidelines set forth in the schedule
7 shall be presumptively correct on the issue of extent and scope of
8 medical treatment. The presumption is rebuttable and may be
9 controverted by a preponderance of scientific medical evidence
10 establishing that a variance from the guidelines is reasonably
11 required to cure or relieve the employee from the effects of his or
12 her injury pursuant to Section 4600. The presumption created is
13 one affecting the burden of proof.

14 (b) The recommended guidelines set forth in the schedule
15 adopted pursuant to subdivision (a) shall reflect practices that are
16 evidence and scientifically based, nationally recognized, and
17 peer-reviewed. The guidelines shall be educational and designed
18 to assist providers by offering an analytical framework for the
19 evaluation and treatment of the more common problems of injured
20 workers, and shall assure appropriate and necessary care for all
21 injured workers diagnosed with industrial conditions.

22 (c) Three months after the publication date of the updated
23 American College of Occupational and Environmental Medicine,
24 Occupational Medicine Practice Guidelines, and continuing until
25 the effective date of a medical treatment utilization schedule,
26 pursuant to Section 5307.27, the recommended guidelines set
27 forth in the American College of Occupational and Environmental
28 Medicine, Occupational Medicine Practice Guidelines shall be
29 presumptively correct on the issue of extent and scope of medical
30 treatment. The presumption is rebuttable and may be controverted
31 by a preponderance of the evidence establishing that a variance
32 from the guidelines is reasonably required to cure and relieve the
33 employee from the effects of his or her injury pursuant to Section
34 4600.

35 (d) Notwithstanding the medical treatment utilization schedule
36 or the guidelines set forth in the American College of Occupational
37 and Environmental Medicine, Occupational Medicine Practice
38 Guidelines, for injuries occurring on and after January 1, 2004, an
39 employee shall be entitled to no more than 24 chiropractic and 24
40 physical therapy visits per industrial injury.



1 (e) The presumption afforded to the treating physician in
2 Section 4062.9 shall not be applicable to cases arising under this
3 section.

4 (f) This section shall not apply when an insurance carrier
5 authorizes, in writing, additional visits to a health care practitioner
6 for physical medicine services.

7 (g) For all injuries not covered by the American College of
8 Occupational and Environmental Medicine, Occupational
9 Medicine Practice Guidelines or official utilization schedule after
10 adoption pursuant to Section 5307.27, authorized treatment shall
11 be in accordance with other evidence-based medical treatment
12 guidelines generally recognized by the national medical
13 community and that are scientifically based.

14 (h) This section shall not be apply to employees and employers
15 whom to Section 4600.3 or 4600.31 applies.

16 SEC. 30. Section 4609 of the Labor Code is repealed.

17 ~~4609. (a) In order to prevent the improper selling, leasing, or~~
18 ~~transferring of a health care provider's contract, it is the intent of~~
19 ~~the Legislature that every arrangement that results in any payor~~
20 ~~paying a health care provider a reduced rate for health care services~~
21 ~~based on the health care provider's participation in a network or~~
22 ~~panel shall be disclosed by the contracting agent to the provider in~~
23 ~~advance and shall actively encourage employees to use the~~
24 ~~network, unless the health care provider agrees to provide~~
25 ~~discounts without that active encouragement.~~

26 ~~(b) Beginning July 1, 2000, every contracting agent that sells,~~
27 ~~leases, assigns, transfers, or conveys its list of contracted health~~
28 ~~care providers and their contracted reimbursement rates to a payor,~~
29 ~~as defined in subparagraph (A) of paragraph (3) of subdivision (d),~~
30 ~~or another contracting agent shall, upon entering or renewing a~~
31 ~~provider contract, do all of the following:~~

32 ~~(1) Disclose whether the list of contracted providers may be~~
33 ~~sold, leased, transferred, or conveyed to other payors or other~~
34 ~~contracting agents, and specify whether those payors or~~
35 ~~contracting agents include workers' compensation insurers or~~
36 ~~automobile insurers.~~

37 ~~(2) Disclose what specific practices, if any, payors utilize to~~
38 ~~actively encourage employees to use the list of contracted~~
39 ~~providers when obtaining medical care that entitles a payor to~~
40 ~~claim a contracted rate. For purposes of this paragraph, a payor is~~



1 ~~deemed to have actively encouraged employees to use the list of~~
2 ~~contracted providers if the employer provides information directly~~
3 ~~to employees during the period the employer has medical control~~
4 ~~advising them of the existence of the list of contracted providers~~
5 ~~through the use of a variety of advertising or marketing approaches~~
6 ~~that supply the names, addresses, and telephone numbers of~~
7 ~~contracted providers to employees; or in advance of a workplace~~
8 ~~injury, or upon notice of an injury or claim by an employee, the~~
9 ~~approaches may include, but are not limited to, the use of provider~~
10 ~~directories, the use of a list of all contracted providers in an area~~
11 ~~geographically accessible to the posting site, the use of wall cards~~
12 ~~that direct employees to a readily accessible listing of those~~
13 ~~providers at the same location as the wall cards, the use of wall~~
14 ~~cards that direct employees to a toll-free telephone number or~~
15 ~~Internet Web site address, or the use of toll-free telephone numbers~~
16 ~~or Internet Web site addresses supplied directly during the period~~
17 ~~the employer has medical control. However, Internet Web site~~
18 ~~addresses alone shall not be deemed to satisfy the requirements of~~
19 ~~this paragraph. Nothing in this paragraph shall prevent contracting~~
20 ~~agents or payors from providing only listings of providers located~~
21 ~~within a reasonable geographic range of an employee. A payor~~
22 ~~who otherwise meets the requirements of this paragraph is deemed~~
23 ~~to have met the requirements of this paragraph regardless of the~~
24 ~~employer's ability to control medical treatment pursuant to~~
25 ~~Sections 4600 and 4600.3.~~

26 ~~(3) Disclose whether payors to which the list of contracted~~
27 ~~providers may be sold, leased, transferred, or conveyed may be~~
28 ~~permitted to pay a provider's contracted rate without actively~~
29 ~~encouraging the employees to use the list of contracted providers~~
30 ~~when obtaining medical care. Nothing in this subdivision shall be~~
31 ~~construed to require a payor to actively encourage the employees~~
32 ~~to use the list of contracted providers when obtaining medical care~~
33 ~~in the case of an emergency.~~

34 ~~(4) Disclose, upon the initial signing of a contract, and within~~
35 ~~15 business days of receipt of a written request from a provider or~~
36 ~~provider panel, a payor summary of all payors currently eligible~~
37 ~~to claim a provider's contracted rate due to the provider's and~~
38 ~~payor's respective written agreements with any contracting agent.~~

39 ~~(5) Allow providers, upon the initial signing, renewal, or~~
40 ~~amendment of a provider contract, to decline to be included in any~~



1 ~~list of contracted providers that is sold, leased, transferred, or~~
2 ~~conveyed to payors that do not actively encourage the employees~~
3 ~~to use the list of contracted providers when obtaining medical care~~
4 ~~as described in paragraph (2). Each provider's election under this~~
5 ~~paragraph shall be binding on the contracting agent with which the~~
6 ~~provider has the contract and any other contracting agent that buys,~~
7 ~~leases, or otherwise obtains the list of contracted providers.~~

8 ~~A provider shall not be excluded from any list of contracted~~
9 ~~providers that is sold, leased, transferred, or conveyed to payors~~
10 ~~that actively encourage the employees to use the list of contracted~~
11 ~~providers when obtaining medical care, based upon the provider's~~
12 ~~refusal to be included on any list of contracted providers that is~~
13 ~~sold, leased, transferred, or conveyed to payors that do not actively~~
14 ~~encourage the employees to use the list of contracted providers~~
15 ~~when obtaining medical care.~~

16 ~~(6) If the payor's explanation of benefits or explanation of~~
17 ~~review does not identify the name of the network that has a written~~
18 ~~agreement signed by the provider whereby the payor is entitled,~~
19 ~~directly or indirectly, to pay a preferred rate for the services~~
20 ~~rendered, the contracting agent shall do the following:~~

21 ~~(A) Maintain a Web site that is accessible to all contracted~~
22 ~~providers and updated at least quarterly and maintain a toll-free~~
23 ~~telephone number accessible to all contracted providers whereby~~
24 ~~providers may access payor summary information.~~

25 ~~(B) Disclose through the use of an Internet Web site, a toll-free~~
26 ~~telephone number, or through a delivery or mail service to its~~
27 ~~contracted providers, within 30 days, any sale, lease assignment,~~
28 ~~transfer or conveyance of the contracted reimbursement rates to~~
29 ~~another contracting agent or payor.~~

30 ~~(7) Nothing in this subdivision shall be construed to impose~~
31 ~~requirements or regulations upon payors, as defined in~~
32 ~~subparagraph (A) of paragraph (3) of subdivision (d).~~

33 ~~(c) Beginning July 1, 2000, a payor, as defined in subparagraph~~
34 ~~(B) of paragraph (3) of subdivision (d), shall do all of the~~
35 ~~following:~~

36 ~~(1) Provide an explanation of benefits or explanation of review~~
37 ~~that identifies the name of the network with which the payor has~~
38 ~~an agreement that entitles them to pay a preferred rate for the~~
39 ~~services rendered.~~



1 ~~(2) Demonstrate that it is entitled to pay a contracted rate within~~
2 ~~30 business days of receipt of a written request from a provider~~
3 ~~who has received a claim payment from the payor. The provider~~
4 ~~shall include in the request a statement explaining why the~~
5 ~~payment is not at the correct contracted rate for the services~~
6 ~~provided. The failure of the provider to include a statement shall~~
7 ~~relieve the payor from the responsibility of demonstrating that it~~
8 ~~is entitled to pay the disputed contracted rate. The failure of a payor~~
9 ~~to make the demonstration to a properly documented request of the~~
10 ~~provider within 30 business days shall render the payor~~
11 ~~responsible for the lesser of the provider's actual fee or, as~~
12 ~~applicable, any fee schedule pursuant to this division, which~~
13 ~~amount shall be due and payable within 10 days of receipt of~~
14 ~~written notice from the provider, and shall bar the payor from~~
15 ~~taking any future discounts from that provider without the~~
16 ~~provider's express written consent until the payor can demonstrate~~
17 ~~to the provider that it is entitled to pay a contracted rate as provided~~
18 ~~in this subdivision. A payor shall be deemed to have demonstrated~~
19 ~~that it is entitled to pay a contracted rate if it complies with either~~
20 ~~of the following:~~

21 ~~(A) Describes the specific practices the payor utilizes to~~
22 ~~comply with paragraph (2) of subdivision (b), and demonstrates~~
23 ~~compliance with paragraph (1).~~

24 ~~(B) Identifies the contracting agent with whom the payor has~~
25 ~~a written agreement whereby the payor is not required to actively~~
26 ~~encourage employees to use the list of contracted providers~~
27 ~~pursuant to paragraph (5) of subdivision (b).~~

28 ~~(d) For the purposes of this section, the following terms have~~
29 ~~the following meanings:~~

30 ~~(1) "Contracting agent" means an insurer licensed under the~~
31 ~~Insurance Code to provide workers' compensation insurance, a~~
32 ~~health care service plan, including a specialized health care service~~
33 ~~plan, a preferred provider organization, or a self-insured~~
34 ~~employer, while engaged, for monetary or other consideration, in~~
35 ~~the act of selling, leasing, transferring, assigning, or conveying a~~
36 ~~provider or provider panel to provide health care services to~~
37 ~~employees for work-related injuries.~~

38 ~~(2) "Employee" means a person entitled to seek health care~~
39 ~~services for a work-related injury.~~



1 ~~(3) (A) For the purposes of subdivision (b), “payor” means a~~
2 ~~health care service plan, including a specialized health care service~~
3 ~~plan, an insurer licensed under the Insurance Code to provide~~
4 ~~disability insurance that covers hospital, medical, or surgical~~
5 ~~benefits, automobile insurance, or workers’ compensation~~
6 ~~insurance, or a self-insured employer that is responsible to pay for~~
7 ~~health care services provided to beneficiaries.~~

8 ~~(B) For the purposes of subdivision (c), “payor” means an~~
9 ~~insurer licensed under the Insurance Code to provide workers’~~
10 ~~compensation insurance, a self-insured employer, a third-party~~
11 ~~administrator or trust, or any other third party that is responsible~~
12 ~~to pay health care services provided to employees for work-related~~
13 ~~injuries, or an agent of an entity included in this definition.~~

14 ~~(4) “Payor summary” means a written summary that includes~~
15 ~~the payor’s name and the type of plan, including, but not limited~~
16 ~~to, a group health plan, an automobile insurance plan, and a~~
17 ~~workers’ compensation insurance plan.~~

18 ~~(5) “Provider” means any of the following:~~

19 ~~(A) Any person licensed or certified pursuant to Division 2~~
20 ~~(commencing with Section 500) of the Business and Professions~~
21 ~~Code.~~

22 ~~(B) Any person licensed pursuant to the Chiropractic Initiative~~
23 ~~Act or the Osteopathic Initiative Act.~~

24 ~~(C) Any person licensed pursuant to Chapter 2.5 (commencing~~
25 ~~with Section 1440) of Division 2 of the Health and Safety Code.~~

26 ~~(D) A clinic, health dispensary, or health facility licensed~~
27 ~~pursuant to Division 2 (commencing with Section 1200) of the~~
28 ~~Health and Safety Code.~~

29 ~~(E) Any entity exempt from licensure pursuant to Section 1206~~
30 ~~of the Health and Safety Code.~~

31 ~~(e) This section shall become operative on July 1, 2000.~~

32 SEC. 31. Section 4611 is added to the Labor Code, to read:

33 4611. (a) Commencing July 1, 2004, there is hereby
34 established the Independent Medical Review System that shall
35 resolve disputes involving any disputed health care service.

36 (b) “Health care service” means any medical treatment, as
37 defined in Section 4600, recommended by a physician, as defined
38 in Section 3209.3, or any disputed diagnostic service
39 recommended by a physician, as defined in Section 3209.3.



1 (c) A dispute over health care service may be submitted by an
2 employee or employer with respect to the denial, modification,
3 delay, or approval of any health care service.

4 (d) In order to request independent medical review under this
5 article, the employee or employer requesting review shall submit
6 to the administrative director a one-page application. All
7 applications for dispute that meet the requirements of this section
8 shall be reviewed. An applicant is not required to have first
9 participated in the process pursuant to Section 4610 in order to be
10 eligible for independent medical review.

11 (e) The administrative director shall notify the court
12 administrator of all requests for independent medical review
13 within five days of receipt of the request. The court administrator
14 shall determine whether the claim of the injured worker seeking
15 independent medical review is subject to any additional disputed
16 issue over which the appeals board has jurisdiction. If such a
17 dispute exists, the court administrator shall promptly notify the
18 board that there is an independent medical review of medical
19 issues in the claim.

20 (f) As used in this division, “permanent and stationary” means
21 that, based on objective findings of medical evidence, no further
22 material improvement would reasonably be expected from
23 additional medical treatment or the passage of time.
24 Notwithstanding any other provision of law, disputes regarding
25 whether an employee is permanent and stationary shall be resolved
26 by the independent medical review system created by this section.

27 SEC. 32. Section 4611.1 is added to the Labor Code, to read:

28 4611.1. (a) The department may contract with one or more
29 independent medical review organizations in the state to conduct
30 reviews for purposes of Section 4611. The director may establish
31 additional requirements, including conflict-of-interest standards,
32 consistent with the purposes of this article, that an organization
33 shall be required to meet in order to qualify for participation in the
34 Independent Medical Review System and to assist the department
35 in carrying out its responsibilities.

36 (b) The independent medical review organizations and the
37 medical professionals selected by these organizations to conduct
38 reviews shall be deemed to be medical consultants for purposes of
39 Section 43.98 of the Civil Code.



1 (c) An independent medical review organization shall conduct
2 the review in accordance with any regulations or orders of the
3 administrative director. The organization's review shall be limited
4 to an examination of the medical necessity of the disputed medical
5 treatment services and shall not include any consideration of
6 compensability or other legal issues.

7 (d) Neither the independent medical review organization, nor
8 any experts it designates to conduct a review, shall have any
9 material professional, familial, or financial affiliation, as
10 determined by the administrative director, with any of the
11 following:

12 (1) The employer, the employer's workers' compensation
13 insurer or third-party claims administrator, or any other entity
14 contracting with the employer to provide utilization review
15 services pursuant to Section 4610.

16 (2) Any officer, director, or employee of the employer's health
17 care provider, workers' compensation insurer, or third-party
18 claims administrator.

19 (3) A physician, the physician's medical group, or the
20 independent practice association involved in the health care
21 service in dispute.

22 (4) The facility or institution at which either the proposed
23 health care service, or the alternative service, if any, recommended
24 by the employer's health care provider, workers' compensation
25 insurer, or third-party claims administrator, would be provided.

26 (5) The development or manufacture of the principal drug,
27 device, procedure, or other therapy proposed by the employee or
28 his or her treating physician whose treatment is under review, or
29 the alternative therapy, if any, recommended by the employer or
30 other entity.

31 (6) The employee or the employee's immediate family.

32 (7) The employee's or employer's legal representative or the
33 legal representative's immediate family.

34 (e) In order to contract with the division for purposes of this
35 section, an independent medical review organization shall meet all
36 of the requirements of the administrative director and shall not be
37 an affiliate, parent organization, or subsidiary of, nor in any way
38 be owned or controlled by, a workers' compensation insurer or
39 third-party claims administrator.



1 (f) Upon receipt of information and documents related to a
2 case, the medical professional reviewer or reviewers selected to
3 conduct the review by the independent medical review
4 organization shall promptly review all pertinent medical records
5 of the employee, medical provider reports, as well as any other
6 information submitted to the organization as authorized by the
7 division or requested by the reviewers from any of the parties to
8 the dispute. If reviewers request information from any of the
9 parties, a copy of the request and the response shall be provided to
10 all of the parties. The reviewer or reviewers shall also review
11 relevant information related to the criteria set forth in subdivision
12 (g).

13 (g) Following its review, the reviewer or reviewers shall
14 determine whether the disputed health care service was medically
15 necessary based on peer-reviewed scientific and objective medical
16 evidence regarding the effectiveness of the disputed service.

17 (h) The organization shall complete its review and make its
18 determination in writing, and in layperson's terms to the maximum
19 extent practicable, within 30 days of the receipt of the application
20 for review and supporting documentation, or within less time as
21 prescribed by the administrative director. If the disputed medical
22 treatment service has not been provided and the employee's
23 provider or the division certifies in writing that an imminent and
24 serious threat to the health of the employee may exist, the analyses
25 and determinations of the reviewers shall be expedited and
26 rendered within three days of the receipt of the information.
27 Subject to the approval of the administrative director, reviews may
28 be extended for up to three days in extraordinary circumstances or
29 for good cause. The administrative director shall adopt regulations
30 specifying a standardized format for, and minimum required
31 elements of, determinations made pursuant to this section.

32 (i) The medical professionals' analyses and determinations
33 shall state whether the disputed health care service is medically
34 necessary. Each analysis shall cite the employee's medical
35 condition, the relevant documents in the record, and any relevant
36 findings associated to support the determination.

37 (j) The independent medical review organization shall
38 promptly serve the administrative director, the employer, the
39 employee, and the employee's treating physician with the analyses
40 and determinations of the medical professionals reviewing the



1 case, and a description of the qualifications of the medical
2 professionals. The determination shall be accompanied by a
3 notice, in a form determined by the administrative director,
4 informing the parties of their appeal rights. The independent
5 medical review organization shall keep the names of the reviewers
6 confidential in all communications with entities or individuals
7 outside the independent medical review organization, except in
8 response to orders of the appeals board or a court. If more than one
9 medical professional reviewed the case and the result was differing
10 determinations, the independent medical review organization
11 shall provide each of the separate reviewer's analyses and
12 determinations.

13 (k) The determination of the independent medical review shall
14 be final and binding upon the parties to the dispute. The
15 determination may not be appealed to the division, a workers'
16 compensation administrative law judge, or the board. Upon a
17 determination by the independent medical treatment review
18 organization that the disputed medical treatment is medically
19 necessary, the employer or other entity shall authorize the disputed
20 medical treatment.

21 (l) The independent medical review record shall be admissible
22 before the appeals board.

23 (m) The independent medical review record shall be made
24 available to a qualified medical examiner or an agreed medical
25 examiner if disputes arise over the compensability of the same
26 injury as was the subject of the independent medical review. Either
27 party to the dispute over compensability may make the
28 independent medical review available to the QME/AME.

29 SEC. 33. Section 4611.2 is added to the Labor Code, to read:

30 4611.2. (a) The cost of the independent medical review
31 authorized under Section 4611 shall be borne by the employer.

32 (b) The administrative director shall establish a reasonable
33 reimbursement schedule for payment of independent medical
34 reviews, including administrative costs.

35 SEC. 34. Section 4614 of the Labor Code is repealed.

36 ~~4614. (a) (1) Notwithstanding Section 5307.1, where the~~
37 ~~employee's individual or organizational provider of health care~~
38 ~~services rendered under this division and paid on a fee for service~~
39 ~~basis is also the provider of health care services under contract with~~
40 ~~the employee's health benefit program, and the service or~~



1 ~~treatment provided is included within the range of benefits of the~~
2 ~~employee's health benefit program, and paid on a fee-for-service~~
3 ~~basis, the amount of payment for services provided under this~~
4 ~~division, for a work-related occurrence or illness, shall be no more~~
5 ~~than the amount that would have been paid for the same services~~
6 ~~under the health benefit plan, for a non-work-related occurrence~~
7 ~~or illness.~~

8 ~~(2) A health care service plan that arranges for health care~~
9 ~~services to be rendered to an employee under this division under~~
10 ~~a contract, and which is also the employee's organizational~~
11 ~~provider for nonoccupational injuries and illnesses, with the~~
12 ~~exception of a nonprofit health care service plan that exclusively~~
13 ~~contracts with a medical group to provide or arrange for medical~~
14 ~~services to its enrollees in a designated geographic area, shall be~~
15 ~~paid by the employer for services rendered under this division only~~
16 ~~on a capitated basis.~~

17 ~~(b) (1) Where the employee's individual or organizational~~
18 ~~provider of health care services rendered under this division who~~
19 ~~is not providing services under a contract is not the provider of~~
20 ~~health care services under contract with the employee's health~~
21 ~~benefit program or where the services rendered under this division~~
22 ~~are not within the benefits provided under the employer-sponsored~~
23 ~~health benefit program, the provider shall receive payment that is~~
24 ~~no more than the average of the payment that would have been paid~~
25 ~~by five of the largest preferred provider organizations by~~
26 ~~geographic region. Physicians, as defined in Section 3209.3, shall~~
27 ~~be reimbursed at the same averaged rates, regardless of licensure,~~
28 ~~for the delivery of services under the same procedure code. This~~
29 ~~subdivision shall not apply to a health care service plan that~~
30 ~~provides its services on a capitated basis.~~

31 ~~(2) The administrative director shall identify the regions and~~
32 ~~the five largest carriers in each region. The carriers shall provide~~
33 ~~the necessary information to the administrative director in the~~
34 ~~form and manner requested by the administrative director. The~~
35 ~~administrative director shall make this information available to the~~
36 ~~affected providers on an annual basis.~~

37 ~~(c) Nothing in this section shall prohibit an individual or~~
38 ~~organizational health care provider from being paid fees different~~
39 ~~from those set forth in the official medical fee schedule by an~~
40 ~~employer, insurance carrier, third-party administrator on behalf of~~



1 employers, or preferred provider organization representing an
2 employer or insurance carrier provided that the administrative
3 director has determined that the alternative negotiated rates
4 between the organizational or individual provider and a payer, a
5 third-party administrator on behalf of employers, or a preferred
6 provider organization will produce greater savings in the
7 aggregate than if each item on billings were to be charged at the
8 scheduled rate.

9 (d) For the purposes of this section, “organizational provider”
10 means an entity that arranges for health care services to be
11 rendered directly by individual caregivers. An organizational
12 provider may be a health care service plan, disability insurer,
13 health care organization, preferred provider organization, or
14 workers’ compensation insurer arranging for care through a
15 managed care network or on a fee-for-service basis. An individual
16 provider is either an individual or institution that provides care
17 directly to the injured worker.

18 SEC. 35. Section 4614.1 of the Labor Code is repealed.

19 ~~4614.1. Notwithstanding subdivision (f) of Section 1345 of~~
20 ~~the Health and Safety Code, a health care service plan licensed~~
21 ~~pursuant to the Knox Keene Health Care Service Plan Act and~~
22 ~~certified by the administrative director pursuant to Section 4600.5~~
23 ~~to provide health care pursuant to Section 4600.3 shall be~~
24 ~~permitted to accept payment from a self-insured employer, a group~~
25 ~~of self-insured employers, or the insurer of an employer on a~~
26 ~~fee-for-service basis for the provision of such health care as long~~
27 ~~as the health care service plan is not both the health care~~
28 ~~organization in which the employee is enrolled and the plan~~
29 ~~through which the employee receives regular health benefits.~~

30 SEC. 36. Section 4658 of the Labor Code is amended to read:

31 4658. (a) For injuries occurring prior to January 1, 1992, if
32 the injury causes permanent disability, the percentage of disability
33 to total disability shall be determined, and the disability payment
34 computed and allowed, according to paragraph (1). However, in
35 no event shall the disability payment allowed be less than the
36 disability payment computed according to paragraph (2).

37 (1)

38



1		Column 2—Number of weeks
2		for which two-thirds of
3	Column 1—Range	average weekly earnings
4	of percentage	allowed for each 1 percent
5	of permanent	of permanent disability
6	disability incurred:	within percentage range:
7	Under 10	3
8	10–19.75	4
9	20–29.75	5
10	30–49.75	6
11	50–69.75	7
12	70–99.75	8

13
 14 The number of weeks for which payments shall be allowed set
 15 forth in column 2 above based upon the percentage of permanent
 16 disability set forth in column 1 above shall be cumulative, and the
 17 number of benefit weeks shall increase with the severity of the
 18 disability. The following schedule is illustrative of the
 19 computation of the number of benefit weeks:

20		
21	Column 1—	
22	Percentage	Column 2—
23	of permanent	Cumulative
24	disability	number of
25	incurred:	benefit weeks:
26	5	15.00
27	10	30.25
28	15	50.25
29	20	70.50
30	25	95.50
31	30	120.75
32	35	150.75
33	40	180.75
34	45	210.75
35	50	241.00
36	55	276.00
37	60	311.00
38	65	346.00
39	70	381.25
40	75	421.25

[4]



1	80	461.25
2	85	501.25
3	90	541.25
4	95	581.25
5	100	for life

6
7 (2) Two-thirds of the average weekly earnings for four weeks
8 for each 1 percent of disability, where, for the purposes of this
9 subdivision, the average weekly earnings shall be taken at not
10 more than seventy-eight dollars and seventy-five cents (\$78.75).

11 (b) This subdivision shall apply to injuries occurring on or after
12 January 1, 1992. If the injury causes permanent disability, the
13 percentage of disability to total disability shall be determined, and
14 the disability payment computed and allowed, according to
15 paragraph (1). However, in no event shall the disability payment
16 allowed be less than the disability payment computed according to
17 paragraph (2).

18 (1)

19		
20		Column 2—Number of weeks
21		for which two-thirds of
22	Column 1—Range	average weekly earnings
23	of percentage	allowed for each 1 percent
24	of permanent	of permanent disability
25	disability incurred:	within percentage range:
26	Under 10	3
27	10–19.75	4
28	20–24.75	5
29	25–29.75	6
30	30–49.75	7
31	50–69.75	8
32	70–99.75	9

33
34 The numbers set forth in column 2 above are based upon the
35 percentage of permanent disability set forth in column 1 above and
36 shall be cumulative, and shall increase with the severity of the
37 disability in the manner illustrated in subdivision (a).

38 (2) Two-thirds of the average weekly earnings for four weeks
39 for each 1 percent of disability, where, for the purposes of this



1 subdivision, the average weekly earnings shall be taken at not
2 more than seventy-eight dollars and seventy-five cents (\$78.75).

3 (c) This subdivision shall apply to injuries occurring on or after
4 January 1, 2004. If the injury causes permanent disability, the
5 percentage of disability to total disability shall be determined, and
6 the disability payment computed and allowed as follows:

7		
8		Column 2—Number of weeks
9		for which two-thirds of
10	Column 1—Range	average weekly earnings
11	of percentage	allowed for each 1 percent
12	of permanent	of permanent disability
13	disability incurred:	within percentage range:
14	Under 10	4
15	10–19.75	5
16	20–24.75	5
17	25–29.75	6
18	30–49.75	7
19	50–69.75	8
20	70–99.75	9

21
22 The numbers set forth in column 2 above are based upon the
23 percentage of permanent disability set forth in column 1 above and
24 shall be cumulative, and shall increase with the severity of the
25 disability in the manner illustrated in subdivision (a).

26 (d) This section shall become inoperative on the January 1st
27 after the Secretary of Labor and Workforce Development files a
28 declaration with the Secretary of State that all of the following
29 have occurred:

30 (1) The cost of workers' compensation insurance, per one
31 hundred dollars (\$100) of payroll, in California is equal to or less
32 than the national average of the remaining 49 states and the
33 District of Columbia for the same period of time.

34 (2) The administrative director has certified that the cost of
35 workers' compensation insurance per one hundred dollars (\$100)
36 of payroll, in California is equal to or less than the national
37 average of the remaining 49 states and the District of Columbia for
38 the same period of time.

[4]



1 (3) *The certification of the administrative director pursuant to*
2 *paragraph (2) has been reviewed and agreed to by the rating*
3 *organization, as defined in Section 11750.1 of the Insurance Code.*

4 SEC. 37. Section 4658.1 is added to the Labor Code, to read:

5 4658.1. (a) For injuries occurring prior to January 1, 1992, if
6 the injury causes permanent disability, the percentage of disability
7 to total disability shall be determined, and the disability payment
8 computed and allowed, according to paragraph (1). However, in
9 no event shall the disability payment allowed be less than the
10 disability payment computed according to paragraph (2).

11 (1)

12

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21

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23

24

25

Column 2—Number of weeks

for which two-thirds of

average weekly earnings

allowed for each 1 percent

of permanent disability

within percentage range:

Under 10	3
10–19.75	4
20–29.75	5
30–49.75	6
50–69.75	7
70–99.75	8

26 The number of weeks for which payments shall be allowed set
27 forth in column 2 above based upon the percentage of permanent
28 disability set forth in column 1 above shall be cumulative, and the
29 number of benefit weeks shall increase with the severity of the
30 disability. The following schedule is illustrative of the
31 computation of the number of benefit weeks:

32

33

34

35

36

37

38

39

40

Column 1—	Column 2—
Percentage	Cumulative
of permanent	number of
disability	benefit weeks:
incurred:	
5	15.00
10	30.25
15	50.25



1	20	70.50
2	25	95.50
3	30	120.75
4	35	150.75
5	40	180.75
6	45	210.75
7	50	241.00
8	55	276.00
9	60	311.00
10	65	346.00
11	70	381.25
12	75	421.25
13	80	461.25
14	85	501.25
15	90	541.25
16	95	581.25
17	100	for life

18

19 (2) Two-thirds of the average weekly earnings for four weeks
20 for each 1 percent of disability, where, for the purposes of this
21 subdivision, the average weekly earnings shall be taken at not
22 more than seventy-eight dollars and seventy-five cents (\$78.75).

23 (b) This subdivision shall apply to injuries occurring on or after
24 January 1, 1992. If the injury causes permanent disability, the
25 percentage of disability to total disability shall be determined, and
26 the disability payment computed and allowed, according to
27 paragraph (1). However, in no event shall the disability payment
28 allowed be less than the disability payment computed according to
29 paragraph (2).

30 (1)

31

32

33

34 Column 1—Range
35 of percentage
36 of permanent
37 disability incurred:

Column 2—Number of weeks
for which two-thirds of
average weekly earnings
allowed for each 1 percent
of permanent disability
within percentage range:

38	Under 10	3
39	10–19.75	4
40	20–24.75	5

[4]



1	25–29.75	6
2	30–49.75	7
3	50–69.75	8
4	70–99.75	9

5
6 The numbers set forth in column 2 above are based upon the
7 percentage of permanent disability set forth in column 1 above and
8 shall be cumulative, and shall increase with the severity of the
9 disability in the manner illustrated in subdivision (a).

10 (2) Two-thirds of the average weekly earnings for four weeks
11 for each 1 percent of disability, where, for the purposes of this
12 subdivision, the average weekly earnings shall be taken at not
13 more than seventy-eight dollars and seventy-five cents (\$78.75).

14 (c) This subdivision shall apply to injuries occurring on or after
15 January 1, 2004. If the injury causes permanent disability, the
16 percentage of disability to total disability shall be determined, and
17 the disability payment computed and allowed as follows:

18		
19		Column 2—Number of weeks
20		for which two-thirds of
21	Column 1—Range	average weekly earnings
22	of percentage	allowed for each 1 percent
23	of permanent	of permanent disability
24	disability incurred:	within percentage range:
25	Under 10	4
26	10–19.75	5
27	20–24.75	5
28	25–29.75	6
29	30–49.75	7
30	50–69.75	8
31	70–99.75	9

32
33 The numbers set forth in column 2 above are based upon the
34 percentage of permanent disability set forth in column 1 above and
35 shall be cumulative, and shall increase with the severity of the
36 disability in the manner illustrated in subdivision (a).

37 (d) This subdivision shall apply to injuries occurring on or after
38 the operative date of this section. If the injury causes permanent
39 disability, the percentage of disability to total disability shall be



1 determined, and the disability payment computed and allowed as
2 follows:

3	4	5
6	7	8
9	10	11
Column 1—Range	Column 2—Number of weeks	for which two-thirds of
of percentage	of average weekly earnings	allowed for each 1 percent
of permanent	of permanent disability	within percentage range:
disability incurred:		
10 Under 10	4	
11 10–19.75	5	
12 20–24.75	5	
13 25–29.75	6	
14 30–49.75	7	
15 50–69.75	8	
16 70–99.75	12	

17
18 The numbers set forth in column 2 above are based upon the
19 percentage of permanent disability set forth in column 1 above and
20 shall be cumulative, and shall increase with the severity of the
21 disability in the manner illustrated in subdivision (a).

22 (e) This section shall only become operative on the January 1st
23 after the Secretary of Labor and Workforce Development files a
24 declaration with the Secretary of State that all of following have
25 occurred:

26 (1) The cost of workers’ compensation insurance, per one
27 hundred dollars (\$100) of payroll, in California is equal to or less
28 than the national average of the remaining 49 states and the District
29 of Columbia for the same period of time.

30 (2) The administrative director has certified that the cost of
31 workers’ compensation insurance, per one hundred dollars (\$100)
32 of payroll, in California is equal to or less than the national average
33 of the remaining 49 states and the District of Columbia for the
34 same period of time.

35 (3) The certification of the administrative director pursuant to
36 paragraph (2) has been reviewed and agreed to by the rating
37 organization, as defined in Section 11750.1 of the Insurance Code.

38 SEC. 38. Section 4658.6 is added to the Labor Code, to read:



1 4658.6. The employer shall not be liable for the supplemental
2 job displacement benefit if the employer meets either of the
3 following conditions:

4 (a) Within 30 days of the termination of temporary disability
5 indemnity payments, the employer offers, and the employee,
6 within 30 days from the date of the offer, rejects, or fails to accept
7 in the form and manner prescribed by the administrative director,
8 modified work, accommodating the employee's work restrictions,
9 lasting at least 12 months.

10 (b) Within 30 days of the termination of temporary disability
11 indemnity payments, the employer offers, and the employee,
12 within 30 days from the date of the offer, rejects, or fails to accept
13 in the form and manner prescribed by the administrative director,
14 alternative work meeting all of the following conditions:

15 (1) The employee has the ability to perform the essential
16 functions of the job provided.

17 (2) The job provided is in a regular position lasting at least 12
18 months.

19 (3) The job provided offers wages and compensation that are
20 within 15 percent of those paid to the employee at the time of
21 injury.

22 (4) The job is located within reasonable commuting distance of
23 the employee's residence at the time of injury.

24 SEC. 39. Section 4660 of the Labor Code is amended to read:

25 4660. (a) In determining the percentages of permanent
26 disability, account shall be taken of the nature of the physical
27 injury or disfigurement, *established by a preponderance of*
28 *medical evidence based upon objective findings, as defined in*
29 *paragraph (2) of subdivision (j) of Section 3139.2, the occupation*
30 *of the injured employee, and his or her age at the time of such the*
31 *injury, consideration being given to the diminished ability of such*
32 *injured employee to compete in an open labor market employee's*
33 *adaptability to perform a given job.*

34 (b) (1) *The nature of the physical injury or disfigurement shall*
35 *be the sole factor to be considered in determining percentages of*
36 *permanent disability if any of the following circumstances exist:*

37 (A) *The employee returns to regular work at the job held at the*
38 *time of injury.*



1 (B) The treating physician releases the injured employee to
2 regular work at the job held at the time of injury and the job is
3 available but the worker refuses to return to that job.

4 (C) The treating physician releases the injured employee to
5 regular work at the job held at the time of injury but the worker's
6 employment is terminated for cause unrelated to the injury.

7 (2) The nature of the physical injury or disfigurement, the
8 occupation of the injured employee, and his or her age at the time
9 of the injury shall be the sole factors to be considered in
10 determining percentages of permanent disability if any of the
11 following circumstances exist:

12 (A) The employee returns to modified or alternative work with
13 the same employer that provides wages and compensation that are
14 not less than 15 percent of those paid to the employee at the time
15 of injury and, if the job is not at the same physical location as the
16 job held at the time of injury, the job is located within reasonable
17 commuting distance of the employee's residence at the time of
18 injury.

19 (B) The treating physician releases the injured employee to
20 regular work at the job offered pursuant to this subdivision and the
21 job is available but the worker refuses to return to that job.

22 (C) The treating physician releases the injured employee to
23 regular work at the job offered pursuant to this subdivision but the
24 worker's employment is terminated for cause unrelated to the
25 injury.

26 (c) (1) The administrative director ~~may~~ shall prepare, adopt,
27 and from time to time amend, a schedule for the determination of
28 the percentage of permanent disabilities in accordance with this
29 section. ~~Such—~~The schedule shall be available for public
30 inspection; and, without formal introduction in evidence, shall be
31 prima facie evidence of the percentage of permanent disability to
32 be attributed to each injury covered by the schedule.

33 ~~(e) Any such schedule and any amendment thereto or revision~~
34 ~~thereof shall apply prospectively and shall apply to and govern~~
35 ~~only those permanent disabilities which result from compensable~~
36 ~~injuries received or occurring on and after the effective date of the~~
37 ~~adoption of such schedule, amendment or revision, as the fact may~~
38 ~~be.~~

39 ~~(d) On or before January 1, 1995, the administrative director~~
40 ~~shall review and revise the schedule for the determination of the~~



1 ~~percentage of permanent disabilities. The revision shall include,~~
2 ~~but not be limited to, an updating of the standard disability ratings~~
3 ~~and occupations to reflect the current labor market. However, no~~
4 ~~change in standard disability ratings shall be adopted without the~~
5 ~~approval of the Commission of Health and Safety and Workers'~~
6 ~~Compensation. A proposed revision shall be submitted to the~~
7 ~~commission on or before July 1, 1994. The schedule shall promote~~
8 *uniformity of ratings for substantially similar disabilities*
9 *throughout the state, and for injuries not subject to subdivision (b)*
10 *or (c) and shall set forth a methodology for determining the*
11 *percentage of permanent disability that gives appropriate weight*
12 *to each of the factors of disability set forth in subdivision (a). The*
13 *schedule shall be promulgated and administered to reflect the*
14 *effects of physical injury or disfigurement on the individual worker*
15 *in combination with the injured worker's adaptability to perform*
16 *a given job. The schedule shall not allow for the determination of*
17 *the percentage of permanent disability to be determined solely*
18 *upon the assessment of the adaptability of the worker to perform*
19 *a given job. The administrative director shall adopt, as an*
20 *emergency regulation, changes to the schedule to reflect medical*
21 *conditions or occupational classifications that were not in effect*
22 *at the time of the promulgation of the schedule within 30 days after*
23 *actual notice that a compensable injury or an occupation at the*
24 *time of injury was not set forth in the schedule at the time the injury*
25 *took place. In developing the schedule, the administrative director*
26 *may utilize for reference nationally recognized guidelines for*
27 *impairment.*

28 (2) *The adoption, amendment, repeal, or readoption of the*
29 *regulations that the administrative director is authorized pursuant*
30 *to paragraph (1) to adopt as emergency regulations are deemed to*
31 *be necessary for the immediate preservation of the public peace,*
32 *health and safety, or general welfare, for purposes of Sections*
33 *11346.1 and 11349.6 of the Government Code, and the*
34 *administrative director is hereby exempted from the requirement*
35 *that it describe specific facts showing the need for immediate*
36 *action. For purposes of subdivision (e) of Section 11346.1 of the*
37 *Government Code, the 120-day period, as applicable to the*
38 *effective period of an emergency regulatory action and submission*
39 *of specified materials to the Office of Administrative Law, is hereby*
40 *extended to 180 days.*



1 (d) For compensable claims arising before the effective date of
2 the schedule and any amendment thereto or revision thereof, the
3 revised schedule shall apply to the determination of permanent
4 disabilities where there has either been no comprehensive
5 medical-legal report, or report by a treating physician, indicating
6 the existence of permanent disability, or where the employer is not
7 required to provide the notice required by Section 4061 to the
8 injured worker.

9 SEC. 40. Section 5705.1 is added to the Labor Code, to read:

10 5705.1. (a) The burden of proof for the apportionment
11 regarding permanent disability under Sections 4663, 4750, and
12 4750.5 shall rest upon the defendant. In accordance with Section
13 3202.5, the defendant shall demonstrate by a preponderance of the
14 evidence, and by reasonable medical probability, that absent the
15 industrial injury, the injured worker had lost, as a consequence of
16 a preexisting injury or illness, some capacity to perform the
17 activity affected by the injury.

18 (b) Notwithstanding any other provision of this code relating
19 to workers' compensation benefits, in denying apportionment the
20 appeals board may not, in determining permanent disability, rely
21 on any medical report that fails to fully address the issue of
22 apportionment and fails to set forth the basis of the medical
23 opinion. In denying apportionment, the appeals board may not rely
24 on any medical report that fails to apportion a previous injury or
25 illness that has been the subject of a prior claim for damages or that
26 fails to provide a discussion of the medical processes by which a
27 previously asserted injury or illness resolved without affecting
28 bodily function.

29 (c) If the applicant has received a prior award of permanent
30 disability, it shall be conclusively presumed that the prior
31 permanent disability exists at the time of any subsequent industrial
32 injury.

33 (d) The accumulation of all permanent disability awards issued
34 to one individual employee shall not exceed 100 percent unless the
35 employee's injury or illness is conclusively presumed to be total
36 in character pursuant to Section 4662.

37 (e) Permanent disability or death benefits shall not be payable
38 unless the industrial injury is the predominant cause of the
39 disability or death when compared to all causes of injury in total.

40 SEC. 41. Section 5814 of the Labor Code is repealed.



1 ~~5814. When payment of compensation has been unreasonably~~
2 ~~delayed or refused, either prior to or subsequent to the issuance of~~
3 ~~an award, the full amount of the order, decision, or award shall be~~
4 ~~increased by 10 percent. Multiple increases shall not be awarded~~
5 ~~for repeated delays in making a series of payments due for the same~~
6 ~~type or specie of benefit unless there has been a legally significant~~
7 ~~event between the delay and the subsequent delay in payments of~~
8 ~~the same type or specie of benefits. The question of delay and the~~
9 ~~reasonableness of the cause therefor shall be determined by the~~
10 ~~appeals board in accordance with the facts. This delay or refusal~~
11 ~~shall constitute good cause under Section 5803 to rescind, alter, or~~
12 ~~amend the order, decision, or award for the purpose of making the~~
13 ~~increase provided for herein.~~

14 SEC. 42. Section 5814 is added to the Labor Code, to read:

15 5814. (a) When payment of compensation has been
16 unreasonably delayed or refused, either prior to or subsequent to
17 the issuance of an award, the amount of the payment unreasonably
18 delayed or refused may be increased up to 15 percent or up to five
19 hundred dollars (\$500), whichever is greater. In proceeding under
20 this section, the appeals board shall use its discretion to accomplish
21 a fair balance and substantial justice between the parties.

22 (b) As a precondition to a claim for penalties under this section,
23 the employee shall give written notice to the employer of the
24 claimed unreasonable delay or refusal of payment of
25 compensation. If, within 20 days from the date of services of this
26 notice, the employer pays a self-imposed increase of 10 percent of
27 the amount of payment delayed or refused, in addition to any other
28 self-imposed increases due under this division, there shall be no
29 further penalty allowed under this section. If the employer disputes
30 whether the delay or refusal is unreasonable, and the workers'
31 compensation administrative law judge determines that the delay
32 or refusal violates this section, the workers' compensation
33 administrative law judge shall award the penalty prescribed in
34 subdivision (a). In determining whether the delay or refusal is
35 unreasonable, the workers' compensation administrative law
36 judge shall consider only the specific facts resulting in the delay
37 or refusal of the specific payment that is the subject of the request
38 for penalties.

39 (c) The appeals board shall have no jurisdiction to hear a claim
40 for penalties under subdivision (a), unless the employee files a



1 claim for a penalty within one year from the date of the alleged
2 unreasonable delay or refusal to pay benefits. Upon the approval
3 of a compromise and release by the appeals board, it shall be
4 conclusively presumed that any existing or potential penalties
5 have been resolved, unless expressly excluded by the terms of the
6 compromise and release.

7 (d) When a penalty is awarded under subdivision (a), the
8 appeals board may allow a credit for any self-imposed increase
9 under subdivision (d) of Section 4650 or subdivision (b), in order
10 to accomplish a fair balance and substantial justice between the
11 parties.

12 (e) Nothing in this section shall be construed to create a civil
13 cause of action.

14 SEC. 43. Section 5814.5 of the Labor Code is repealed.

15 ~~5814.5. When the payment of compensation has been~~
16 ~~unreasonably delayed or refused subsequent to the issuance of an~~
17 ~~award by an employer that has secured the payment of~~
18 ~~compensation pursuant to Section 3700, the appeals board shall,~~
19 ~~in addition to increasing the order, decision, or award pursuant to~~
20 ~~Section 5814, award reasonable attorneys' fees incurred in~~
21 ~~enforcing the payment of compensation awarded.~~

22 SEC. 44. Section 15 of Chapter 635 of the Statutes of 2003
23 shall not become operative.

24 SEC. 45. Section 27 of Chapter 639 of the Statutes of 2003
25 shall not become operative.

26 SEC. 46. Section 47 of Chapter 639 of the Statutes of 2003
27 shall not become operative.

28 SEC. 47. This act is an urgency statute necessary for the
29 immediate preservation of the public peace, health, or safety
30 within the meaning of Article IV of the Constitution and shall go
31 into immediate effect. The facts constituting the necessity are:

32 In order to provide relief to the state from the effects of the
33 current workers' compensation crisis at the earliest possible time,
34 it is necessary for this act to take effect immediately.

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