PROPOSED CONFERENCE REPORT NO. 1
APRIL 15, 2004

AMENDED IN ASSEMBLY JULY 14, 2003

AMENDED IN SENATE APRIL 21, 2003

SENATE BILL No. 899

Introduced by Senator Poochigian
(Coauthors: Senators Machado, Florez, Aanestad, Battin, Karnette, Margett, McPherson, Perata, Scott, and Speier)
(Coauthors: Assembly Members Parra, Aghazarian, Bogh, Cohn, Dutra, Dutton, Firebaugh, Frommer, Harman, Jerome Horton, Keene, Leno, Leslie, Liu, Maddox, Matthews, McCarthy, Montanez, Nakanishi, Nation, Nunez, Reyes, Salinas, Samuelian, Simitian, Strickland, Wolk, and Wyland)

February 21, 2003

~~An act relating to workers' compensation.~~ *An act to amend Sections 62.5, 139.2, 139.48, 2699, 3201.5, 3201.7, 3201.9, 3202.5, 3207, 3823, 4060, 4061, 4062, 4062.1, 4062.5, 4600, 4603.2, 4604.5, 4650, 4656, 4658, 4660, 4706.5, 4903.05, 5402, 5703, and 6401.7 of, to amend, repeal, and add Section 5814 of, to add Sections 138.65, 4062.3, 4062.8, 4658.1, 4664, and 5814.6 to, to add Article 2.3 (commencing with Section 4616) to Chapter 2 of Part 2 of Division 4 of, to repeal Sections 4062.01, 4062.9, 4750, and 4750.5 of, to repeal and add Sections 4062.2 and 4663 of, and to repeal, add, and repeal Section 139.5 of, the Labor Code, relating to workers' compensation, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 899, as amended, Poochigian. Workers' compensation.

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

Existing law establishes the Workers' Compensation Administration Revolving Fund as a special account in the State Treasury and moneys in the fund may be expended by the Department of Industrial Relations, upon appropriation by the Legislature, for the administration of the workers' compensation program.

This bill would expand the purposes for which money in the fund may be used to include the Return-to-Work Program.

Existing law requires that 80% of the costs of the program be borne by the General Fund and 20% of the costs of the program be borne by the employers through assessments levied by the Director of Industrial Relations.

This bill would instead refer to the assessments as surcharges and require that these employer surcharges account for the total costs of the program.

Existing law requires the Administrative Director of the Division of Workers' Compensation to conduct a study of medical treatment provided to workers who have sustained industrial injuries and illnesses.

This bill would require the administrative director, after consultation with the Insurance Commissioner, to contract with a qualified organization to study the 2003 and 2004 legislative reforms on insurance rates. It would require insurers to submit to the contracting organization information, as established by the contracting organization, at least quarterly and annually. It would require the study to be submitted to the Governor, the Insurance Commissioner, and the Legislature on or before January 1, 2006. The bill would require the Governor and the Insurance Commissioner to review the study, make recommendations, and permit them to submit proposals to the Legislature if they make certain determinations. It would require insurers to bear up to $1,000,000 of the cost of the study.

Existing law requires the administrative director to appoint qualified medical evaluators in each of the respective specialties as required for the evaluation of medical-legal issues. Existing law further requires the administrative director to adopt regulations concerning procedures to be followed by all qualified medical evaluators in evaluating the existence and extent of permanent impairment and limitations resulting

from the injury, and specifies the factors upon which these evaluations are to be based.

This bill would delete these factors and would require that the evaluations be conducted in a manner consistent with other specified standards.

Existing law permits aggrieved employees to bring civil actions to recover penalties for violations of the Labor Code, but does not alter the exclusive remedy provided by the workers' compensation provisions of the code.

This bill would provide that the right to recover these penalties does not apply to the recovery of penalties in connection with the workers' compensation provisions of the code.

Existing law requires the administrative director to adopt regulations regarding procedures governing the determination of any disputed medical issues.

This bill would require that these procedures be consistent with standards used in connection with the medical treatment utilization schedule adopted by the administrative director.

Existing law, until January 1, 2009, requires the administrative director to establish the Return-to-Work Program in order to promote the early and sustained return to work of the employee following a work-related injury, and to pay a wage reimbursement, workplace modification expense reimbursement, and premium reimbursement to an employer that employs 100 or fewer employees, if certain conditions are met.

This bill would eliminate the payment of wage reimbursement and premium reimbursement from the program. The bill would instead make reimbursements under the program available, to the extent funds are available, for an eligible employer, as defined.

Existing law establishes the Workers' Compensation Return-to-Work Fund as a special fund in the State Treasury, moneys from which may be expended by the administrative director, upon appropriation by the Legislature, only for purposes of making the above reimbursements.

This bill would provide that the fund shall consist of certain penalties imposed in connection with delayed or refused compensation payments and transfers made by the administrative director from the Workers' Compensation Administration Revolving Fund.

Existing law, until January 1, 2004, required the administrative director to establish a vocational rehabilitation unit to perform duties in connection with vocational rehabilitation services, and provided that

when an employee was determined to be medically eligible and chose to participate in a vocational rehabilitation program, he or she would continue to receive temporary disability benefits, a maintenance allowance, and additional living expenses. Chapter 639 of the Statutes of 2003, which became effective on January 1, 2004, eliminated vocational rehabilitation as part of the workers' compensation system.

This bill, until January 1, 2009, would reenact the above provisions relating to vocational rehabilitation for employees injured prior to January 1, 2004.

Existing law requires any insurer, self-insured employer, 3rd-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care to report the apparent fraudulent claim.

This bill would prohibit any person making such a report in good faith from being subject to any civil liability.

Existing law authorizes collective bargaining agreements between a private employer or groups of employers engaged in construction-related activities and a recognized or certified exclusive bargaining representative that establishes 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 other alternative workers' compensation programs. Existing law also authorizes similar dispute resolution provisions contained in labor-management agreements.

This bill would authorize parties to these agreements to negotiate any aspect of the delivery of medical benefits and the delivery of disability compensation to the employees who are eligible for health care coverage for nonoccupational injuries and illnesses through their employer. It would also require the Commission on Health and Safety and Workers' Compensation, on or before June 30, 2006, and annually thereafter, to prepare and publish a report in connection with these provisions.

Existing law requires that workers' compensation provisions be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment.

Existing law prohibits this provision from being construed as relieving a party or a lien claimant from meeting the evidentiary burden of proof by a preponderance of the evidence.

This bill would repeal this provision and instead would require that all parties and lien claimants shall meet the evidentiary burden of proof on all issues by a preponderance of the evidence in order that all parties are considered equal before the law.

Existing law establishes procedures for the resolution of disputes regarding the compensability of an injury. Existing law also establishes procedures, including procedures regarding the selection of agreed and qualified medical evaluators, that apply if the parties do not agree to a permanent disability rating based on the treating physician's evaluation and the employee is represented by an attorney, as well as when the employee is not represented by an attorney.

This bill would revise and recast these provisions.

Existing law provides that regardless of the date of injury, if the employee has been treated by his or her personal physician, no presumption of correctness shall apply to the opinion of that physician on the issue of extent and scope of medical treatment, either prior or subsequent to the issuance of an award, unless the physician or chiropractor was predesignated prior to the date of injury, in which case the opinion of that physician or chiropractor is presumed to be correct.

This bill would repeal this presumption. It would also revise provisions in connection with the predesignation of a physician prior to injury.

Existing law generally provides for the reimbursement of medical providers for services rendered in connection with the treatment of a worker's injury.

This bill would limit the amounts paid for these services to the reasonable maximum amounts in the official medical fee schedule in effect on the date of service.

Existing law requires an employer to provide all medical services reasonably required to cure or relieve the injured worker from the effects of the injury.

This bill would define medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the injury.

Existing law permits an employee, after 30 days from the date the injury is reported, to be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic distance.

This bill, instead, would authorize the employee to be treated by a physician or at a facility of his or her own choice under these provisions if the employer has not established a medical provider network.

This bill would authorize an insurer or employer, as defined, on or after January 1, 2005, to establish a medical provider network for the provision of medical treatment to injured employees, and would require the administrative director to approve the plans for these medical provider networks. The bill would require an injured employee to select a physician from the provider network to provide treatment for the injury. The bill would permit an employee to obtain 2nd and 3rd opinions regarding treatment from physicians within the network and would establish an independent medical review process to resolve disputes regarding whether the treatment is medically necessary.

Existing law provides that upon adoption by the administrative director of a medical treatment utilization schedule, the recommended guidelines set forth in the schedule create a rebuttable presumption of correctness on the issue and extent and scope of medical treatment of a worker's injuries.

This bill would provide that the presumption may be controverted by a preponderance of the scientific medical evidence and would provide that the presumption is one affecting the burden of proof.

Existing law further requires that the recommended guidelines set forth in the medical treatment utilization schedule reflect practices as generally accepted by the health care community.

This bill instead would require that the guidelines be evidence and scientifically based, nationally recognized, and peer-reviewed.

Existing law provides that until the medical treatment utilization schedule is adopted by the administrative director, the guidelines set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment.

This bill would provide that this presumption is applicable regardless of the date of injury.

Existing law provides that for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic and 24 physical therapy visits per industrial injury.

This bill would similarly provide that an employee shall be entitled to no more than 24 occupational therapy visits per industrial injury.

Existing law prohibits aggregate disability payments for a single injury occurring on or after January 1, 1979, causing temporary partial disability, from extending for more than 240 compensable weeks within a period of 5 years from the date of injury.

This bill would instead prohibit aggregate disability payments for a single injury occurring on or after the effective date of this bill, causing temporary disability, from extending for more than 104 compensable weeks within a period of 2 years from the date of commencement of temporary disability payment, except if an employee suffers from certain injuries or conditions.

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.

This bill would require, rather than authorize, the administrative director to amend the schedule at least once every 5 years. The bill would provide that the schedule as revised pursuant to changes made in legislation enacted during the 2003–04 Regular and Extraordinary Sessions would apply to comparable compensable claims arising before January 1, 2005, under certain circumstances. It also would require the schedule to promote consistency, uniformity, and objectivity.

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 eliminate the requirement to consider the ability of the injured employee to compete in the open labor market and, instead, would require that consideration be given to an employee's diminished future earning capacity, which would be a numeric formula based on criteria established by the bill. The bill would require the nature of the physical injury or disfigurement to incorporate descriptions and measurements contained in a specific publication of the American Medical Association. It would also require the administrative director to formulate the adjusted rating schedule based on empirical data and findings contained in a specified report, and to adopt regulations, on or before January 1, 2005, to implement the changes made to these provisions by this bill.

Existing law provides that when the extent of permanent disability cannot be determined at the date of last payment of temporary disability

indemnity, the employer nevertheless shall commence and continue to make the timely payment of permanent disability until the employer's reasonable estimate of permanent disability indemnity due has been paid.

This bill would instead require the employer to commence and continue the timely payment of permanent disability indemnity based on a reasonable estimate of the amount due at the end of the period for the payment of temporary disability indemnity specified above, regardless of whether the extent of permanent disability can be determined at that date.

Existing law provides a schedule containing the method for the computation of permanent disability benefits.

This bill would establish the schedule for the computation of these benefits, for injuries occurring on or after the effective date of the revised permanent disability schedule adopted by the administrative director pursuant to this bill, with the amounts under the schedule to be increased by 15% if, within 60 days of the disability becoming permanent and stationary, the employee is offered regular work, modified work, or alternative work, as defined, that lasts at least 12 months. The bill would provide that this schedule for permanent disability payments also would apply to compensable claims arising before April 30, 2004, under certain circumstances. The bill would exempt employers that employ fewer than 50 employees from the above provisions of the schedule.

Existing law contains provisions with respect to the apportionment of permanent disability in connection with an employee's injury or condition.

This bill would repeal and recast these provisions. This bill would additionally require any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury to address the issue of causation of the disability. It would also require an employee who claims an industrial injury to disclose, upon request, all previous permanent disabilities or physical impairments, and would impose limits on the percentage of permanent disability an employee may receive.

Existing law provides for the filing of a claim form by the injured employee with the employer and also provides that if liability is not rejected within 90 days after that form is filed, the injury is presumed compensable.

This bill would provide that within one working day after an employee files a claim form, the employer shall authorize the provision of treatment, for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. It would, however, limit liability for medical treatment to $10,000 until the date the claim is accepted or rejected.

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%.

This bill would make these provisions inoperative on June 1, 2004, and repeal them as of January 1, 2005. The bill would, instead, commencing June 1, 2004, prescribe procedures under which, when the payment of compensation has been unreasonably delayed or refused, the amount of the payment unreasonably delayed or refused shall be increased up to 25% or $10,000, whichever is less. The bill would provide that these provisions shall apply to all injuries, without regard to the date of the injury. It would permit an employer to pay a self-imposed penalty in lieu of the penalty that may be awarded by the appeals board.

The bill would provide that any employer or insurer that knowingly delays or refuses to pay compensation with a frequency that indicates a general business practice is liable for administrative penalties of not to exceed $400,000, which would be deposited in the Return-to-Work Fund.

Existing law authorizes the Workers' Compensation Appeals Board to receive as evidence and use as proof of any fact in dispute various reports, statements, publications, and medical treatment protocols. Existing law requires the administrative director to adopt guidelines for use in the medical treatment utilization schedule.

This bill would authorize the appeals board to receive as evidence the medical treatment utilization guidelines or the medical treatment utilization guidelines adopted by the administrative director.

Existing law requires every employer to establish, implement, and maintain an effective injury prevention program. Existing law also authorizes an employer to adopt the Model Injury and Illness Prevention Program for Non-High-Hazard Employment and the Model Injury and Illness Prevention Program for Employers in Industries with Intermittent Employment, developed by the Division of Occupational Safety and Health. Existing law requires every workers' compensation insurer to conduct a review of these injury and illness prevention

programs of each of its insureds within 4 months of the commencement of the initial insurance policy term.

This bill would instead require any workers' compensation insurer to conduct a review of these programs of each of its insureds with an experience modification of 2.0 or greater to determine whether the insured has implemented all of the required components within 6 months of the commencement of the initial insurance policy term.

The bill would also make various conforming changes.

This bill would declare that it would take effect immediately as an urgency statute.

~~Existing law provides that an injury of an employee arising out of and in the course of employment is generally compensable through the workers' compensation system.~~

~~This bill would state the intent of the Legislature to improve the workers' compensation system by promoting the efficient delivery of high quality appropriate medical care.~~

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

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

~~SECTION 1. It is the intent of the Legislature to improve the~~

SECTION 1. Section 62.5 of the Labor Code is amended to read:

62.5. (a) The Workers' Compensation Administration Revolving Fund is hereby created as a special account in the State Treasury. Money in the fund may be expended by the department, upon appropriation by the Legislature, for the administration of the workers' compensation program set forth in this division and Division 4 (commencing with Section 3200), other than the activities financed pursuant to Section 3702.5, *and the Return-to-Work Program set forth in Section 139.48,* and may not be used *or borrowed* for any other purpose.

(b) The fund shall consist of ~~assessments~~ *surcharges* made pursuant to subdivision (e). ~~Costs to the program shall be shared on a proportional basis between the General Fund and employer assessments. The General Fund appropriation shall account for 80 percent and employer assessments shall account for 20 percent of the total costs of the program.~~

(c) (1) The Uninsured Employers Benefits Trust Fund is hereby created as a special trust fund account in the State Treasury, of which the director is trustee, and its sources of funds are as provided in subdivision (e). Notwithstanding Section 13340 of the Government Code, the fund is continuously appropriated for the payment of nonadministrative expenses of the workers' compensation program for workers injured while employed by uninsured employers in accordance with Article 2 (commencing with Section 3710) of Chapter 4 of Part 1 of Division 4, and shall not be used for any other purpose. All moneys collected shall be retained in the trust fund until paid as benefits to workers injured while employed by uninsured employers. Nonadministrative expenses include audits and reports of services prepared pursuant to subdivision (b) of Section 3716.1. The ~~assessment~~ *surcharge* amount for this fund shall be stated separately.

(2) Notwithstanding any other provision of law, all references to the Uninsured Employers Fund shall mean the Uninsured Employers Benefits Trust Fund.

(3) Notwithstanding paragraph (1), in the event that budgetary restrictions or impasse prevent the timely payment of administrative expenses from the Workers' Compensation Administration Revolving Fund, those expenses shall be advanced from the Uninsured Employers Benefits Trust Fund. Expense advances made pursuant to this paragraph shall be reimbursed in full to the Uninsured Employers Benefits Trust Fund upon enactment of the annual Budget Act.

(d) (1) The Subsequent Injuries Benefits Trust Fund is hereby created as a special trust fund account in the State Treasury, of which the director is trustee, and its sources of funds are as provided in subdivision (e). Notwithstanding Section 13340 of the Government Code, the fund is continuously appropriated for the nonadministrative expenses of the workers' compensation program for workers who have suffered serious injury and who are suffering from previous and serious permanent disabilities or physical impairments, in accordance with Article 5 (commencing with Section ~~4750)~~ *4751)* of Chapter 2 of Part 2 of Division 4, and Section 4 of Article XIV of the California Constitution, and shall not be used for any other purpose. All moneys collected shall be retained in the trust fund until paid as benefits to workers who have suffered serious injury and who are suffering from previous and

serious permanent disabilities or physical impairments. Nonadministrative expenses include audits and reports of services pursuant to subdivision (c) of Section 4755. The ~~assessment~~ *surcharge* amount for this fund shall be stated separately.

(2) Notwithstanding any other provision of law, all references to the Subsequent Injuries Fund shall mean the Subsequent Injuries Benefits Trust Fund.

(3) Notwithstanding paragraph (1), in the event that budgetary restrictions or impasse prevent the timely payment of administrative expenses from the Workers' Compensation Administration Revolving Fund, those expenses shall be advanced from the Subsequent Injuries Benefits Trust Fund. Expense advances made pursuant to this paragraph shall be reimbursed in full to the Subsequent Injuries Benefits Trust Fund upon enactment of the annual Budget Act.

(e) (1) Separate ~~assessments~~ *surcharges* shall be levied by the director upon all employers, as defined in Section 3300, for purposes of deposit in the Workers' Compensation Administration Revolving Fund, the Uninsured Employers Benefits Trust Fund, and the Subsequent Injuries Benefits Trust Fund. The total amount of the ~~assessments~~ *surcharges* shall be allocated between self-insured employers and insured employers in proportion to payroll respectively paid in the most recent year for which payroll information is available. The director shall adopt reasonable regulations governing the manner of collection of the ~~assessments~~ *surcharges*. The regulations shall require the ~~assessments~~ *surcharges* to be paid by self-insurers to be expressed as a percentage of indemnity paid during the most recent year for which information is available, and the ~~assessments~~ *surcharges* to be paid by insured employers to be expressed as a percentage of premium. In no event shall the ~~assessments~~ *surcharges* paid by insured employers be considered a premium for computation of a gross premium tax or agents' commission. *In no event shall the total amount of the surcharges paid by insured and self-insured employers exceed the amounts reasonably necessary to carry out the purposes of this section.*

(2) The regulations adopted pursuant to paragraph (1) shall be exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 1.5. Section 138.65 is added to the Labor Code, to read:

138.65. (a) The administrative director, after consultation with the Insurance Commissioner, shall contract with a qualified organization to study the effects of the 2003 and 2004 legislative reforms on workers' compensation insurance rates. The study shall do, but not be limited to, all of the following:

(1) Identify and quantify the savings generated by the reforms.

(2) Review workers' compensation insurance rates to determine the extent to which the reform savings were reflected in rates. When reviewing the rates, consideration shall be given to an insurer's premium revenue, claim costs, and surplus levels.

(3) Assess the effect of the reform savings on replenishing surpluses for workers' compensation insurance coverage.

(4) Review the effects of the reforms on the workers' compensation insurance rates, marketplace, and competition.

(5) Review the adequacy and accuracy of the pure premium rate as recommended by the Workers' Compensation Insurance Bureau and the pure premium rate adopted by the Insurance Commissioner.

(b) Insurers shall submit to the contracting organization premium revenue, claims costs, and surplus levels in different timing aggregates as established by the contracting organization, but at least quarterly and annually. The contracting organization may also request additional materials when appropriate. The contracting organization and the commission shall maintain strict confidentiality of the data. An insurer that fails to comply with the reporting requirements of this subdivision is subject to Section 11754 of the Insurance Code.

(c) The administrative director shall submit to the Governor, the Insurance Commissioner, and the President pro Tempore of the Senate, the Speaker of the Assembly, and the chairs of the appropriate policy committees of the Legislature, a progress report on the study on January 1, 2005, and July 1, 2005, and the final study on or before January 1, 2006. The Governor and the Insurance Commissioner shall review the results of the study and make recommendations as to the appropriateness of regulating insurance rates. If, after reviewing the study, the Governor and the Insurance Commissioner determine that the rates do not appropriately reflect the savings and the timing of the savings associated with the 2003 and 2004 reforms, the Governor and the

Insurance Commissioner may submit proposals to the Legislature. The proposals shall take into consideration how rates should be regulated, and by whom. In no event shall the proposals unfairly penalize insurers that have properly reflected the 2003 and 2004 reforms in their rates, or can verify that they have not received any cost savings as a result of the reforms.

(d) The cost of the study shall be borne by the insurers up to one million dollars ($1,000,000). The cost of the study shall be allocated to an insurer based on the insurer's proportionate share of the market.

SEC. 2. Section 139.2 of the Labor Code is amended to read:

139.2. (a) The administrative director shall appoint qualified medical evaluators in each of the respective specialties as required for the evaluation of medical-legal issues. The appointments shall be for two-year terms.

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

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

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

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

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

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

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

(D) Has qualifications that the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, both deem to be equivalent to board certification in a specialty.

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

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

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

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

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

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

(C) Has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders, and

has served as an agreed medical evaluator on eight or more occasions prior to January 1, 1990.

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

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

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

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

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

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

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

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

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

(e) The administrative director may, in his or her discretion, suspend or terminate a qualified medical evaluator during his or her term of appointment without a hearing as provided under subdivision (k) or (*l*) whenever either of the following conditions occurs:

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

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

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

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

(h) (1) When ~~the injured worker is not represented by an attorney~~ *requested by an employee or employer pursuant to Section 4062.1*, the medical director appointed pursuant to Section 122~~,~~ shall assign three-member panels of qualified medical evaluators within five working days after receiving a request for a panel. If a panel is not assigned within 15 working days, the employee shall have the right to obtain a medical evaluation from

any qualified medical evaluator of his or her choice. The medical director shall use a random selection method for assigning panels of qualified medical evaluators. The medical director shall select evaluators who are specialists of the type ~~selected~~ *requested* by the employee. The medical director shall advise the employee that he or she should consult with his or her treating physician prior to deciding which type of specialist to request.

(2) The administrative director shall promulgate a form that shall notify the employee of the physicians selected for his or her panel *after a request has been made pursuant to Section 4062.1 or 4062.2*. The form shall include, for each physician on the panel, the physician's name, address, telephone number, specialty, number of years in practice, and a brief description of his or her education and training, and shall advise the employee that he or she is entitled to receive transportation expenses and temporary disability for each day necessary for the examination. The form shall also state in a clear and conspicuous location and type: ''You have the right to consult with an information and assistance officer at no cost to you prior to selecting the doctor to prepare your evaluation, or you may consult with an attorney. If your claim eventually goes to court, the workers' compensation administrative law judge will consider the evaluation prepared by the doctor you select to decide your claim.''

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

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

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

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

(4) When the medical director determines that an employee has requested an evaluation by a type of specialist that is appropriate for the employee's injury, but there are not enough qualified medical evaluators of that type within the general geographic area of the employee's residence to establish a three-member panel, the

medical director shall include sufficient qualified medical evaluators from other geographic areas and the employer shall pay all necessary travel costs incurred in the event the employee selects an evaluator from another geographic area.

(i) The medical director appointed pursuant to Section 122~~,~~ shall continuously review the quality of comprehensive medical evaluations and reports prepared by agreed and qualified medical evaluators and the timeliness with which evaluation reports are prepared and submitted. The review shall include, but not be limited to, a review of a random sample of reports submitted to the division, and a review of all reports alleged to be inaccurate or incomplete by a party to a case for which the evaluation was prepared. The medical director shall submit to the administrative director an annual report summarizing the results of the continuous review of medical evaluations and reports prepared by agreed and qualified medical evaluators and make recommendations for the improvement of the system of medical evaluations and determinations.

(j) After public hearing pursuant to Section 5307.3, the administrative director shall adopt regulations concerning the following issues:

(1) *(A)* Standards governing the timeframes within which medical evaluations shall be prepared and submitted by agreed and qualified medical evaluators. Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure. The administrative director shall develop regulations governing the provision of extensions of the 30-day period in *both of the following* cases: ~~(A) where~~

(i) When the evaluator has not received test results or consulting physician's evaluations in time to meet the 30-day ~~deadline; and, (B) to~~ *deadline.*

(ii) To extend the 30-day period by not more than 15 days when the failure to meet the 30-day deadline was for good cause. ~~For~~

(B) For purposes of ~~this subdivision~~ *subparagraph (A)*, ''good cause'' means *any of the following*: ~~(i) medical~~

(i) Medical emergencies of the evaluator or evaluator's ~~family; (ii) death~~ *family.*

(ii) Death in the evaluator's ~~family; or, (iii) natural~~ *family.*

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

(C) The administrative director shall develop timeframes governing availability of qualified medical evaluators for unrepresented employees under Sections 4061 and 4062. These timeframes shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, but shall also permit the employee to waive this right for a specified period of time thereafter.

(2) Procedures to be followed by all physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury *in a manner consistent with Section 4660*. ~~In order to produce complete, accurate, uniform, and replicable evaluations, the procedures shall require that an evaluation of anatomical loss, functional loss, and the presence of physical complaints be supported, to the extent feasible, by medical findings based on standardized examinations and testing techniques generally accepted by the medical community.~~

(3) Procedures governing the determination of any disputed medical *treatment* issues *in a manner consistent with Section 5307.27*.

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

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

(A) A medical-legal evaluation that has not been defined and valued pursuant to Section 5307.6. The guidelines shall establish minimum times for patient contact in the conduct of the evaluations, and shall be consistent with regulations adopted pursuant to Section 5307.6.

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

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

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

(k) Except as provided in this subdivision, the administrative director may, in his or her discretion, suspend or terminate the privilege of a physician to serve as a qualified medical evaluator if the administrative director, after hearing pursuant to subdivision (*l*), determines, based on substantial evidence, that a qualified medical evaluator:

(1) Has violated any material statutory or administrative duty.

(2) Has failed to follow the medical procedures or qualifications established pursuant to paragraph (2), (3), (4), or (5) of subdivision (j).

(3) Has failed to comply with the timeframe standards established pursuant to subdivision (j).

(4) Has failed to meet the requirements of subdivision (b) or (c).

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

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

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

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

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

(*l*) The administrative director shall cite the qualified medical evaluator for a violation listed in subdivision (k) and shall set a hearing on the alleged violation within 30 days of service of the citation on the qualified medical evaluator. In addition to the authority to terminate or suspend the qualified medical evaluator

upon finding a violation listed in subdivision (k), the administrative director may, in his or her discretion, place a qualified medical evaluator on probation subject to appropriate conditions, including ordering continuing education or training. The administrative director shall report to the appropriate licensing board the name of any qualified medical evaluator who is disciplined pursuant to this subdivision.

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

(n) Each qualified medical evaluator shall pay a fee, as determined by the administrative director, for appointment or reappointment. These fees shall be based on a sliding scale as established by the administrative director. All revenues from fees paid under this subdivision shall be deposited into the Workers' Compensation Administration Revolving Fund and are available for expenditure upon appropriation by the Legislature, and shall not be used by any other department or agency or for any purpose other than administration of the programs the Division of Workers' Compensation related to the provision of medical treatment to injured employees.

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

SEC. 3. Section 139.48 of the Labor Code is amended to read:

139.48. (a) *(1)* The administrative director shall establish the Return-to-Work Program in order to promote the early and sustained return to work of the employee following a work-related injury or illness.

(2) This section shall be implemented to the extent funds are available.

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

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

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

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

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

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

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

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

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

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

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

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

~~(2) An employer that employs 100 or fewer employees on the date of injury may be reimbursed for 100 percent of the workers' compensation insurance premium paid for the employee for up to two years. An employer that employs more than 100 employees on the date of injury may be reimbursed for 50 percent of the workers' compensation insurance premium paid for the employee for up to two years. The period subject to premium reimbursement shall begin on the first day after the end of the 12-month period for premium rebate provided in subdivision (a) of Section 4638 and shall continue for a maximum of two years.~~

~~(3) The premium reimbursement shall be paid to the employer annually after each consecutive period of 12 months, provided that the qualified injured worker continues modified or alternative employment with that employer in a regular position that pays at~~

~~least 85 percent of the employee's pre-injury wages and compensation.~~

~~(f)~~

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

~~(g)~~

(e) For purposes of this section, ~~"employee"~~ *the following definitions apply:*

(1) "Eligible employer" means any employer, except the state or an employer eligible to secure the payment of compensation pursuant to subdivision (c) of Section 3700, who employs 50 or fewer full-time employees on the date of injury.

(2) "Employee" means a worker who has suffered a work-related injury or illness on or after July 1, 2004.

~~(h)~~

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

~~(i)~~

(g) The Workers' Compensation Return-to-Work Fund is hereby created as a special fund in the State Treasury. *The fund shall consist of all penalties collected pursuant to Section 5814.6 and transfers made by the administrative director from the Workers' Compensation Administration Revolving Fund established pursuant to Section 62.5.* The fund shall be administered by the administrative director. Moneys in the fund may be expended by the administrative director, upon appropriation by the Legislature, only for purposes of implementing this section. ~~The unencumbered balance remaining in the fund as of January 1, 2009, shall revert to the General Fund.~~

~~(j)~~

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

~~(k) This section shall not be implemented unless and until funds are appropriated by the Legislature for this purpose in the annual Budget Act or other statute commencing with the 2004–05 fiscal year.~~

~~(l)~~

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

SEC. 4. Section 139.5 of the Labor Code is repealed.

~~139.5. (a) Except as provided in Section 4658.6, if the injury causes permanent partial disability and the injured employee does not return to work for the employer within 60 days of the termination of temporary disability, the injured employee shall be eligible for a supplemental job displacement benefit in the form of a nontransferable voucher for education-related retraining or skill enhancement, or both, at state approved or accredited schools, as follows:~~

~~(1) Up to four thousand dollars ($4,000) for permanent partial disability awards of less than 15 percent.~~

~~(2) Up to six thousand dollars ($6,000) for permanent partial disability awards between 15 and 25 percent.~~

~~(3) Up to eight thousand dollars ($8,000) for permanent partial disability awards between 26 and 49 percent.~~

~~(4) Up to ten thousand dollars ($10,000) for permanent partial disability awards between 50 and 99 percent.~~

~~(b) The voucher may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement. No more than 10 percent of the voucher moneys may be used for vocational or return to work counseling. The administrative director shall adopt regulations governing the form of payment, direct reimbursement to the injured employee upon presentation to the employer of appropriate documentation and receipts, and any other matters necessary to the proper administration of the supplemental job displacement benefit.~~

~~(c) Within 10 days of the last payment of temporary disability the employer shall provide to the employee in the form and manner prescribed by the administrative director information that~~

~~provides notice of rights under this section. This notice shall be sent by certified mail.~~

~~(d) This section shall apply to injuries occurring on or after January 1, 2004.~~

SEC. 5. Section 139.5 is added to the Labor Code, to read:

139.5. (a) The administrative director shall establish a vocational rehabilitation unit, which shall include appropriate professional staff, and which shall have all of the following duties:

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

(2) To develop rules and regulations, to be adopted by the administrative director, providing for a procedure in which an employee may waive the services of a qualified rehabilitation representative where the employee has been enrolled and made substantial progress toward completion of a degree or certificate from a community college, California State University, or the University of California and desires a plan to complete the degree or certificate. These rules and regulations shall provide that this waiver, as well as any plan developed without the assistance of a qualified rehabilitation representative, must be approved by the rehabilitation unit.

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

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

(5) To develop a fee schedule, to be adopted by the administrative director, governing reasonable fees for vocational rehabilitation services provided on and after January 1, 1991. The initial fee schedule adopted under this paragraph shall be designed to reduce the cost of vocational rehabilitation services by 10 percent from the level of fees paid during 1989. On or before July 1, 1994, the administrative director shall establish the maximum aggregate permissible fees that may be charged for counseling. Those fees shall not exceed four thousand five hundred

dollars ($4,500) and shall be included within the sixteen thousand dollar ($16,000) cap. The fee schedule shall permit up to (A) three thousand dollars ($3,000) for vocational evaluation, evaluation of vocational feasibility, initial interview, vocational testing, counseling and research for plan development, and preparation of the Division of Workers' Compensation Form 102, and (B) three thousand five hundred dollars ($3,500) for plan monitoring, job seeking skills, and job placement research and counseling. However, in no event shall the aggregate of (A) and (B) exceed four thousand five hundred dollars ($4,500).

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

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

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

The employee also shall receive additional living expenses necessitated by the vocational rehabilitation services, together with all reasonable and necessary vocational training, at the expense of the employer, but in no event shall the expenses, counseling fees, training, maintenance allowance, and costs associated with, or arising out of, vocational rehabilitation services incurred after the employee's request for vocational rehabilitation services, except temporary disability payments, exceed sixteen thousand dollars ($16,000). The administrative director shall adopt regulations to ensure that the continued receipt of vocational rehabilitation maintenance allowance

benefits is dependent upon the injured worker's regular and consistent attendance at, and participation in, his or her vocational rehabilitation program.

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

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

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

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

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

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

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

(h) It shall be unlawful for a qualified rehabilitation representative or rehabilitation counselor to refer any employee to any work evaluation facility or to any education or training program if the qualified rehabilitation representative or rehabilitation counselor, or a spouse, employer, co-employee, or any party with whom he or she has entered into contract, express or implied, has any proprietary interest in or contractual relationship with the work evaluation facility or education or training program. It shall also be unlawful for any insurer to refer any injured worker to any rehabilitation provider or facility if the insurer has a proprietary interest in the rehabilitation provider or facility or for any insurer to charge against any claim for the expenses of employees of the insurer to provide vocational rehabilitation services unless those expenses are disclosed to the insured and agreed to in advance.

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

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

(k) This section shall apply only to injuries occurring before January 1, 2004.

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

SEC. 5.5. Section 2699 of the Labor Code is amended to read:

2699. (a) Notwithstanding any other provision of law, any provision of this code that provides for a civil penalty to be

assessed and collected by the Labor and Workforce Development Agency or any of its departments, divisions, commissions, boards, agencies, or employees, for a violation of this code, may, as an alternative, be recovered through a civil action brought by an aggrieved employee on behalf of himself or herself and other current or former employees.

(b) For purposes of this part, ''person'' has the same meaning as defined in Section 18.

(c) For purposes of this part, ''aggrieved employee'' means any person who was employed by the alleged violator and against whom one or more of the alleged violations was committed.

(d) For purposes of this part, whenever the Labor and Workforce Development Agency, or any of its departments, divisions, commissions, boards, agencies, or employees has discretion to assess a civil penalty, a court is authorized to exercise the same discretion, subject to the same limitations and conditions, to assess a civil penalty.

(e) For all provisions of this code except those for which a civil penalty is specifically provided, there is established a civil penalty for a violation of these provisions, as follows:

(1) If, at the time of the alleged violation, the person does not employ one or more employees, the civil penalty is five hundred dollars ($500).

(2) If, at the time of the alleged violation, the person employs one or more employees, the civil penalty is one hundred dollars ($100) for each aggrieved employee per pay period for the initial violation and two hundred dollars ($200) for each aggrieved employee per pay period for each subsequent violation.

(3) If the alleged violation is a failure to act by the Labor and Workplace Development Agency, or any of its departments, divisions, commissions, boards, agencies, or employees, there shall be no civil penalty.

(f) An aggrieved employee may recover the civil penalty described in subdivision (e) in a civil action filed on behalf of himself or herself and other current or former employees against whom one or more of the alleged violations was committed. Any employee who prevails in any action shall be entitled to an award of reasonable attorney's fees and costs. Nothing in this section shall operate to limit an employee's right to pursue other remedies

available under state or federal law, either separately or concurrently with an action taken under this section.

(g) No action may be maintained under this section by an aggrieved employee if the agency or any of its departments, divisions, commissions, boards, agencies, or employees, on the same facts and theories, cites a person for a violation of the same section or sections of the Labor Code under which the aggrieved employee is attempting to recover a civil penalty on behalf of himself or herself or others or initiates a proceeding pursuant to Section 98.3.

(h) Except as provided in subdivision (i), civil penalties recovered by aggrieved employees shall be distributed as follows: 50 percent to the General Fund, 25 percent to the Labor and Workforce Development Agency for education of employers and employees about their rights and responsibilities under this code, available for expenditure upon appropriation by the Legislature, and 25 percent to the aggrieved employees.

(i) Civil penalties recovered under paragraph (1) of subdivision (e) shall be distributed as follows: 50 percent to the General Fund and 50 percent to the Labor and Workforce Development Agency available for expenditure upon appropriation by the Legislature.

(j) Nothing contained in this part is intended to alter or otherwise affect the exclusive remedy provided by the workers' compensation provisions of this code for liability against an employer for the compensation for any injury to or death of an employee arising out of and in the course of employment.

(k) This section shall not apply to the recovery of administrative and civil penalties in connection with the workers' compensation law as contained in Division 1 (commencing with Section 50) and Division 4 (commencing with Section 3200), including, but not limited to, Sections 129.5 and 132a.

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

3201.5. (a) Except as provided in subdivisions (b) and (c), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between a private employer or groups of employers engaged in construction, construction maintenance, or activities limited to rock, sand, gravel, cement and asphalt operations, heavy-duty mechanics, surveying, and construction

inspection and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

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

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

(3) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(4) Joint labor management safety committees.

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

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

(b) *(1)* Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this

division. The portion of any agreement that violates this ~~subdivision~~ *paragraph* shall be declared null and void.

(2) The parties may negotiate any aspect of the delivery of medical benefits and the delivery of disability compensation to employees of the employer or group of employers that are eligible for group health benefits and nonoccupational disability benefits through their employer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) By June 30, 1996, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify Members of the Legislature that a report authorized by this section is available

upon request. The report based upon aggregate data shall include the following:

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

(2) The number of claims filed.

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

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

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

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

(7) Safety history.

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

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

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

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

SEC. 7. Section 3201.7 of the Labor Code is amended to read:

3201.7. (a) Except as provided in subdivision (b), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any labor-management agreement that meets all of the following requirements:

(1) The labor-management agreement has been negotiated separate and apart from any collective bargaining agreement covering affected employees.

(2) The labor-management agreement is restricted to the establishment of the terms and conditions necessary to implement this section.

(3) The labor-management agreement has been negotiated in accordance with the authorization of the administrative director pursuant to subdivision (d), between an employer or groups of employers and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

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

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

(C) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(D) Joint labor management safety committees.

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

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

(b) *(1)* Nothing in this section shall allow a labor-management agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division; nor shall any agreement authorized by this section deny to any employee the right to representation by counsel at all stages during the alternative dispute resolution process. The portion of any agreement that violates this ~~subdivision~~ *paragraph* shall be declared null and void.

(2) The parties may negotiate any aspect of the delivery of medical benefits and the delivery of disability compensation to employees of the employer or group of employers that are eligible for group health benefits and nonoccupational disability benefits through their employer.

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

(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000) or more, and employing at least 50 employees, or any employer that paid an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000), and employing at least 50 employees in at least one of the previous three years.

(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, that develops or projects annual workers' compensation insurance premiums of five hundred thousand dollars ($500,000) or more.

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

(d) Any recognized or certified exclusive bargaining representative in an industry not covered by Section 3201.5, may file a petition with the administrative director seeking permission to negotiate with an employer or group of employers to enter into a labor-management agreement pursuant to this section. The

petition shall specify the bargaining unit or units to be included, the names of the employers or groups of employers, and shall be accompanied by proof of the labor union's status as the exclusive bargaining representative. The current collective bargaining agreement or agreements shall be attached to the petition. The petition shall be in the form designated by the administrative director. Upon receipt of the petition, the administrative director shall promptly verify the petitioner's status as the exclusive bargaining representative. If the petition satisfies the requirements set forth in this subdivision, the administrative director shall issue a letter advising each employer and labor representative of their eligibility to enter into negotiations, for a period not to exceed one year, for the purpose of reaching agreement on a labor-management agreement pursuant to this section. The parties may jointly request, and shall be granted, by the administrative director, an additional one-year period to negotiate an agreement.

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

(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the labor-management agreement and the approximate number of employees who will be covered thereby.

(2) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the labor-management agreement.

(3) The name, address, and telephone number of the contact person of the employer.

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

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

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

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

(g) Commencing July 1, 2005, and annually thereafter, the Division of Workers' Compensation shall report to the Director of Industrial Relations the number of labor-management agreements received and the number of employees covered by these agreements.

(h) By June 30, 2006, and annually thereafter, the administrative director shall prepare and notify Members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

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

(2) The number of claims filed.

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

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

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

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

(7) Safety history.

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

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

(10) Overall worker satisfaction.

The division shall have the authority to require employers and groups of employers participating in labor-management agreements pursuant to this section to provide the data listed above.

(i) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (f) and (g) based on the labor-management agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis, the

administrative director shall make available an updated list of employers and unions entering into labor-management agreements authorized by this section.

SEC. 8. Section 3201.9 of the Labor Code is amended to read:

3201.9. (a) On or before June 30, 2004, and biannually thereafter, the report required in subdivision (i) of Section 3201.5 and subdivision ~~(i)~~ *(h)* of Section 3201.7 shall include updated loss experience for all employers and groups of employers participating in a program established under those sections. The report shall include updated data on each item set forth in subdivision (i) of Section 3201.5 and subdivision ~~(i)~~ *(h)* of Section 3201.7 for the previous year for injuries in 2003 and beyond. Updates for each program shall be done for the original program year and for subsequent years. The insurers, the Department of Insurance, and the rating organization designated by the Insurance Commissioner pursuant to Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 of the Insurance Code, shall provide the administrative director with any information that the administrative director determines is reasonably necessary to conduct the study.

(b) Commencing on and after June 30, 2004, the Insurance Commissioner, or the commissioner's designee, shall prepare for inclusion in the report required in subdivision (i) of Section 3201.5 and subdivision ~~(i)~~ *(h)* of Section 3201.7 a review of both of the following:

(1) The adequacy of rates charged for these programs, including the impact of scheduled credits and debits.

(2) The comparative results for these programs with other programs not subject to Section 3201.5 or Section 3201.7.

(c) Upon completion of the report, the administrative director shall report the findings to the Legislature, the Department of Insurance, the designated rating organization, and the programs and insurers participating in the study.

(d) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state.

SEC. 9. Section 3202.5 of the Labor Code is amended to read:

3202.5. ~~Nothing contained in Section 3202 shall be construed as relieving a party or a lien claimant from meeting the evidentiary burden of proof by a preponderance of the evidence.~~ *All parties*

and lien claimants shall meet the evidentiary burden of proof on all issues by a preponderance of the evidence in order that all parties are considered equal before the law. "Preponderance of the evidence" means ~~such~~ *that* evidence ~~as~~ *that*, when weighed with that opposed to it, has more convincing force and the greater probability of truth. When weighing the evidence, the test is not the relative number of witnesses, but the relative convincing force of the evidence.

SEC. 10. Section 3207 of the Labor Code is amended to read:

3207. "Compensation" means compensation under ~~Division 4~~ *this division* and includes every benefit or payment conferred by ~~Division 4~~ *this division* upon an injured employee, ~~including vocational rehabilitation,~~ or in the event of his *or her* death, upon his *or her* dependents, without regard to negligence.

SEC. 11. Section 3823 of the Labor Code is amended to read:

3823. (a) The administrative director shall, in coordination with the Bureau of Fraudulent Claims of the Department of Insurance, the Medi-Cal Fraud Task Force, and the Bureau of Medi-Cal Fraud and Elder Abuse of the Department of Justice, *or their successor entities,* adopt protocols, to the extent that these protocols are applicable to achieve the purpose of subdivision (b), similar to those adopted by the Department of Insurance concerning medical billing and provider fraud.

(b) Any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care, as described in Section 4600, shall report the apparent fraudulent claim in the manner prescribed by subdivision (a).

(c) No insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that reports any apparent fraudulent claim under this section shall be subject to any civil liability in a cause of action of any kind when the insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person acts in good faith, without malice, and reasonably believes that the action taken was warranted by the known facts, obtained by reasonable efforts. Nothing in this section is intended to, nor does in any manner, abrogate or lessen the existing common

law or statutory privileges and immunities of any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person.

SEC. 12. Section 4060 of the Labor Code is amended to read:

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

(b) Neither the employer nor the employee shall be liable for any comprehensive medical-legal evaluation performed by other than the treating physician ~~either in whole or in part on behalf of the employee prior to the filing of a claim form and prior to the time the claim is denied or becomes presumptively compensable under Section 5402~~ *, except as provided in this section*. However, reports of treating physicians shall be admissible.

(c) If a medical evaluation is required to determine compensability at any time after the ~~period specified in subdivision (b)~~ *filing of the claim form*, and the employee is represented by an attorney, ~~each party may select a qualified medical evaluator to conduct a comprehensive medical-legal evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The parties may, at any time, agree on one medical evaluator to evaluate the issues in dispute~~ *a medical evaluation to determine compensability shall be obtained only by the procedure provided in Section 4062.2*.

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

~~employee has received a comprehensive medical-legal evaluation under this subdivision, and he or she later becomes represented by an attorney, he or she shall not be entitled to an additional evaluation at the employer's expense~~ *the employer shall provide the employee with notice either that the employer requests a comprehensive medical evaluation to determine compensability or that the employer has not accepted liability and the employee may request a comprehensive medical evaluation to determine compensability. Either party may request a comprehensive medical evaluation to determine compensability. The evaluation shall be obtained only by the procedure provided in Section 4062.1.*

(e) ~~Evaluations performed under this section shall not be limited to the issue of the compensability of the injury, but shall address all medical issues in dispute.~~ *(1) Each notice required by subdivision (d) shall describe the administrative procedures available to the injured employee and advise the employee of his or her right to consult an information and assistance officer or an attorney. It shall contain the following language:*

"Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits."

(2) The notice required by subdivision (d) shall be accompanied by the form prescribed by the administrative director for requesting the assignment of a panel of qualified medical evaluators.

SEC. 13. Section 4061 of the Labor Code is amended to read:

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

(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. The notice shall include information

concerning how the employee may obtain a formal medical evaluation pursuant to subdivision (c) *or (d)* if he or she disagrees with the position taken by the employer. The notice shall be accompanied by the form prescribed by the administrative director for requesting assignment of a panel of qualified medical evaluators, unless the employee is represented by an attorney. If the employer determines permanent disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the determination was made and whether there is need for continuing medical care.

(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine the need for continuing medical care, or at which time the employer will advise the employee of the amount of permanent disability indemnity the employer has determined to be payable. If an employee is provided notice pursuant to this paragraph and the employer later takes the position that the employee has no permanent impairment or limitations resulting from the injury, or later determines permanent disability indemnity is payable, the employer shall in either event, within 14 days of the determination to take either position, provide the employee with the notice specified in paragraph (1).

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

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

(c) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation ~~or the assessment of need for continuing medical care~~, and the employee is represented by an attorney, ~~the employer shall seek agreement with the employee on a physician to prepare a comprehensive medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed to by the parties, the parties may not later select an agreed medical evaluator. Evaluations of an employee's permanent impairment and limitations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, either party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense~~ *a medical evaluation to determine permanent disability shall be obtained as provided in Section 4062.2*.

(d) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation, and if the employee is not represented by an attorney, the employer shall ~~not seek agreement with the employee on a physician to prepare an additional medical evaluation. The employer shall~~ immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. ~~The employee shall select a physician from the panel to prepare a medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury.~~

~~For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the report of the qualified medical evaluator and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or the employer on the issues subject to this section.~~ *Either party may request a comprehensive medical evaluation to determine permanent disability, and the evaluation shall be obtained only by the procedure provided in Section 4062.1*.

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

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

~~(g) The unrepresented employee shall be responsible for making an appointment with a qualified medical evaluator selected from a panel of three qualified medical evaluators. The evaluator shall give the employee, at the appointment, a brief opportunity to ask questions concerning the evaluation process and the evaluator's background. The unrepresented employee shall then participate in the evaluation as requested by the evaluator unless the employee has good cause to discontinue the evaluation. For purposes of this subdivision, ''good cause'' shall include evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion, or sexual preference or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure. If the unrepresented employee declines to proceed with the evaluation, he or she shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a comprehensive medical evaluation. If the appeals board subsequently determines that the employee did not have good cause to not proceed with the evaluation, the cost of the evaluation shall be deducted from any award the employee obtains.~~

~~(h) Upon selection or assignment pursuant to subdivision (c) or (d), the medical evaluator shall perform a comprehensive medical evaluation according to the procedures promulgated by the administrative director under paragraphs (2) and (3) of subdivision (j) of Section 139.2 and summarize the medical findings on a form prescribed by the administrative director. The comprehensive medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a comprehensive medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible,~~

~~shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.~~

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

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

~~(k)~~

(f) Any comprehensive medical evaluation concerning an unrepresented employee which indicates that part or all of an employee's permanent impairment or limitations may be subject to apportionment pursuant to Sections 4663 ~~or 4750~~ *and 4664* shall first be submitted by the administrative director to a workers' compensation judge who may refer the report back to the qualified medical evaluator for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.

~~(l)~~

(g) Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating or obtain additional information from the treating physician or medical evaluator to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the procedures promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2. This request shall be in writing, shall specify the reasons the rating should be reconsidered, and shall be served on the other party. If the administrative director finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the administrative

director shall return the report to the treating physician or qualified medical evaluator for appropriate action as the administrative director instructs. Upon receipt of the treating physician's or qualified medical evaluator's final comprehensive medical evaluation and summary form, the administrative director shall recalculate the permanent disability rating according to Section 4660 and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer.

~~(m)~~

(h) (1) If a comprehensive medical evaluation from the treating physician or an agreed medical evaluator or a qualified medical evaluator selected from a three-member panel resolves any issue so as to require an employer to provide compensation, the employer shall commence the payment of compensation or promptly commence proceedings before the appeals board to resolve the dispute. ~~If~~

(2) If the employee and employer agree to a stipulated findings and award as provided under Section 5702 or to compromise and release the claim under Chapter 2 (commencing with Section 5000) of Part 3, or if the employee wishes to commute the award under Chapter 3 (commencing with Section 5100) of Part 3, the appeals board shall first determine whether the agreement or commutation is in the best interests of the employee and whether the proper procedures have been followed in determining the permanent disability rating. The administrative director shall promulgate a form to notify the employee, at the time of service of any rating under this section, of the options specified in this subdivision, the potential advantages and disadvantages of each option, and the procedure for disputing the rating.

~~(n)~~

(i) No issue relating to the existence or extent of permanent impairment and limitations ~~or the need for continuing medical care~~ resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician or an agreed or qualified medical evaluator. With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations ~~or need for continuing medical care~~ resulting from the injury shall be obtained ~~prior to service of the comprehensive medical evaluation on the~~

~~employee and employer if the employee is unrepresented, or prior to the attempt to select an agreed medical evaluator if the employee is represented~~*, except in accordance with Section 4062.1 or 4062.2*. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. ~~However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury and comprehensive medical evaluations prepared by a qualified medical evaluator selected by an unrepresented employee from a three-member panel shall be admissible.~~

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

4062. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning ~~the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, the extent and scope of medical treatment, the existence of new and further disability, or~~ any ~~other~~ medical issues not covered by Section 4060 or 4061 *and not subject to Section 4610*, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610. *If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision.* These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, ~~the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical~~

~~evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation~~ *a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained*.

(b) The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation. Examinations shall be scheduled on an expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. If the second opinion report recommends surgery, the employer shall authorize the surgery. If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed. The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision.

(c) The second opinion physician shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.

(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.

(6) The employee or the employee's immediate family.

~~(d) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. Except in cases where the treating physician's recommendation that spinal surgery be performed pursuant to subdivision (b), the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.~~

~~(e) Upon completing a determination of the disputed medical issue, the physician selected under subdivision (a) or (d) to perform the medical evaluation shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.~~

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

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

~~(h) This section shall remain in effect only until January 1, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2007, deletes or extends that date.~~

SEC. 15. Section 4062.01 of the Labor Code is repealed.

~~4062.01. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, the extent and scope of medical treatment, the existence of new and further disability, or any other medical issues not covered by Section 4060 or 4061, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee~~

~~is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.~~

~~(b) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. The evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.~~

~~(c) Upon completing a determination of the disputed medical issue, the physician selected under subdivision (a) or (b) to perform the medical evaluation shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the~~

~~employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.~~

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

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

~~(f) This section shall become operative on January 1, 2007.~~

SEC. 16. Section 4062.1 of the Labor Code is amended to read:

4062.1. *(a)* If an employee is not represented by an attorney, the employer shall not seek agreement with the employee on an agreed medical evaluator, nor shall an agreed medical evaluator prepare the formal medical evaluation on any issues in dispute.

(b) If either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062, either party may submit the form prescribed by the administrative director requesting the medical director to assign a panel of three qualified medical evaluators in accordance with Section 139.2. However, the employer may not submit the form unless the employee has not submitted the form within 10 days after the employer has furnished the form to the employee and requested the employee to submit the form. The party submitting the request form shall designate the specialty of the physicians that will be assigned to the panel.

(c) Within 10 days of the issuance of a panel of qualified medical evaluators, the employee shall select a physician from the panel to prepare a medical evaluation, the employee shall schedule the appointment, and the employee shall inform the

employer of the selection and the appointment. If the employee does not inform the employer of the selection within 10 days of the assignment of a panel of qualified medical evaluators, then the employer may select the physician from the panel to prepare a medical evaluation. If the employee informs the employer of the selection within 10 days of the assignment of the panel but has not made the appointment, or if the employer selects the physician pursuant to this subdivision, then the employer shall arrange the appointment. Upon receipt of written notice of the appointment arrangements from the employee, or upon giving the employee notice of an appointment arranged by the employer, the employer shall furnish payment of estimated travel expense.

(d) The evaluator shall give the employee, at the appointment, a brief opportunity to ask questions concerning the evaluation process and the evaluator's background. The unrepresented employee shall then participate in the evaluation as requested by the evaluator unless the employee has good cause to discontinue the evaluation. For purposes of this subdivision, "good cause" shall include evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion, or sexual preference or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure. If the unrepresented employee declines to proceed with the evaluation, he or she shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a comprehensive medical evaluation. If the appeals board subsequently determines that the employee did not have good cause to not proceed with the evaluation, the cost of the evaluation shall be deducted from any award the employee obtains.

(e) If an employee has received a comprehensive medical-legal evaluation under this section, and he or she later becomes represented by an attorney, he or she shall not be entitled to an additional evaluation.

SEC. 17. Section 4062.2 of the Labor Code is repealed.

~~4062.2. (a) As part of their agreement on an evaluator, the parties shall agree what information is to be provided to the agreed medical evaluator.~~

~~(b) Any party may provide to the qualified medical evaluator selected by an unrepresented worker from a three-member panel any of the following information:~~

~~(1) Records prepared or maintained by the employee's treating physician or physicians.~~

~~(2) Medical and nonmedical records relevant to determination of the medical issue.~~

~~(c) Information which a party proposes to provide to the qualified medical evaluator selected by an unrepresented worker from a three-member panel shall be served on the opposing party 20 days before the information is provided to the evaluator. If the opposing party objects to consideration of nonmedical records within 10 days thereafter, the records shall not be provided to the evaluator. Either party may use discovery to establish the accuracy or authenticity of nonmedical records prior to the evaluation.~~

~~(d) In any formal medical evaluation, the agreed or qualified medical evaluator shall identify the following:~~

~~(1) All information received from the parties.~~

~~(2) All information reviewed in preparation of the report.~~

~~(3) All information relied upon in the formulation of his or her opinion.~~

~~(e) All communications with an agreed medical evaluator or a qualified medical evaluator selected by an unrepresented worker from a three-member panel before a formal medical evaluation shall be in writing and shall be served on the opposing party 20 days in advance of the evaluation. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party when sent to the medical evaluator.~~

~~(f) Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected by an unrepresented worker from a three-member panel is prohibited. If a party communicates with the agreed medical evaluator or the qualified medical evaluator selected by an unrepresented worker from a three-member panel in violation of subdivision (d), the aggrieved party may elect to terminate the formal medical evaluation and seek a new evaluation from another qualified medical evaluator, or proceed with the initial evaluation.~~

~~(g) The party making the communication prohibited by this section shall be subject to being charged with contempt before the appeals board and shall be liable for the costs incurred by the aggrieved party as a result of the prohibited communication, including the cost of the formal medical evaluation, additional discovery costs, and attorney's fees for related discovery.~~

~~(h) This section shall not apply to oral communications by the employee or, if the employee is deceased, the employee's dependent, or to forms and documents requested by the evaluator or provided by the evaluator to the employee or, if the employee is deceased, the employee's dependent, pursuant to the examination.~~

SEC. 18. Section 4062.2 is added to the Labor Code, to read:

4062.2. (a) Whenever a comprehensive medical evaluation is required to resolve any dispute arising out of an injury or a claimed injury occurring on or after January 1, 2005, and the employee is represented by an attorney, the evaluation shall be obtained only as provided in this section.

(b) If either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062, either party may commence the selection process for an agreed medical evaluator by making a written request naming at least one proposed physician to be the evaluator. The parties shall seek agreement with the other party on the physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days of the first written proposal that names a proposed agreed medical evaluator, or any additional time not to exceed 20 days agreed to by the parties, either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation. The party submitting the request shall designate the specialty of the medical evaluator, the specialty of the medical evaluator requested by the other party if it has been made known to the party submitting the request, and the specialty of the treating physician. The party submitting the request form shall serve a copy of the request form on the other party.

(c) Within 10 days of assignment of the panel by the administrative director, the parties shall confer and attempt to agree upon an agreed medical evaluator selected from the panel. If the parties have not agreed on a medical evaluator from the panel by the 10th day after assignment of the panel, each party may then strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator. If a party fails to exercise the right to strike a name from the panel within three working days of gaining the right to do so, the other party may select any physician who remains on the panel to serve as the

medical evaluator. The administrative director may prescribe the form, the manner, or both, by which the parties shall conduct the selection process.

(d) The represented employee shall be responsible for arranging the appointment for the examination, but upon his or her failure to inform the employer of the appointment within 10 days after the medical evaluator has been selected, the employer may arrange the appointment and notify the employee of the arrangements.

(e) If an employee has received a comprehensive medical-legal evaluation under this section, and he or she later ceases to be represented, he or she shall not be entitled to an additional evaluation.

SEC. 19. Section 4062.3 is added to the Labor Code, to read:

4062.3. (a) Any party may provide to the qualified medical evaluator selected from a panel any of the following information:

(1) Records prepared or maintained by the employee's treating physician or physicians.

(2) Medical and nonmedical records relevant to determination of the medical issue.

(b) Information that a party proposes to provide to the qualified medical evaluator selected from a panel shall be served on the opposing party 20 days before the information is provided to the evaluator. If the opposing party objects to consideration of nonmedical records within 10 days thereafter, the records shall not be provided to the evaluator. Either party may use discovery to establish the accuracy or authenticity of nonmedical records prior to the evaluation.

(c) If an agreed medical evaluator is selected, as part of their agreement on an evaluator, the parties shall agree on what information is to be provided to the agreed medical evaluator.

(d) In any formal medical evaluation, the agreed or qualified medical evaluator shall identify the following:

(1) All information received from the parties.

(2) All information reviewed in preparation of the report.

(3) All information relied upon in the formulation of his or her opinion.

(e) All communications with an agreed medical evaluator or a qualified medical evaluator selected from a panel before a medical evaluation shall be in writing and shall be served on the opposing

party 20 days in advance of the evaluation. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party when sent to the medical evaluator.

(f) Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected from a panel is prohibited. If a party communicates with the agreed medical evaluator or the qualified medical evaluator in violation of subdivision (e), the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from another qualified medical evaluator to be selected according to Section 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation.

(g) The party making the communication prohibited by this section shall be subject to being charged with contempt before the appeals board and shall be liable for the costs incurred by the aggrieved party as a result of the prohibited communication, including the cost of the medical evaluation, additional discovery costs, and attorney's fees for related discovery.

(h) Subdivisions (e) and (f) shall not apply to oral or written communications by the employee or, if the employee is deceased, the employee's dependent, in the course of the examination or at the request of the evaluator in connection with the examination.

(i) Upon completing a determination of the disputed medical issue, the medical evaluator shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator.

(j) If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

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

SEC. 20. Section 4062.5 of the Labor Code is amended to read:

4062.5. If a qualified medical evaluator selected ~~by an unrepresented employee from a three-member~~ *from a* panel fails to complete the formal medical evaluation within the timeframes established by the administrative director pursuant to paragraph (1) of subdivision (j) of Section 139.2, ~~the employee shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a formal medical evaluation~~ *a new evaluation may be obtained upon the request of either party, as provided in Sections 4062.1 or 4062.2*. Neither the employee nor the employer shall have any liability for payment for the formal medical evaluation which was not completed within the required timeframes unless the employee *or employer*, on ~~a form~~ *forms* prescribed by the administrative director, ~~waives his or her~~ *each waive the* right to a new evaluation and elects to accept the original evaluation even though it was not completed within the required timeframes.

SEC. 21. Section 4062.8 is added to the Labor Code, to read:

4062.8. The administrative director shall develop, not later than January 1, 2004, and periodically revise as necessary thereafter, educational materials to be used to provide treating physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, with information and training in basic concepts of workers' compensation, the role of the treating physician, the conduct of permanent and stationary evaluations, and report writing, as appropriate.

SEC. 22. Section 4062.9 of the Labor Code is repealed.

~~4062.9. (a) In cases where an additional comprehensive medical evaluation is obtained under Section 4061 or 4062, if the employee has been treated by his or her personal physician, or by his or her personal chiropractor, as defined in Section 4601, who was predesignated prior to the date of injury as provided under Section 4600, the findings of the personal physician or personal chiropractor are presumed to be correct. This presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of disability. However, the presumption shall not apply where both parties select qualified medical examiners.~~

~~(b) In all cases other than those specified in subdivision (a), regardless of the date of injury, no presumption shall apply to the opinion of any physician on the issue of extent and scope of medical treatment, either prior or subsequent to the issuance of an award.~~

~~(c) The administrative director shall develop, not later than January 1, 2004, and periodically revise as necessary thereafter, educational materials to be used to provide treating physicians and chiropractors with information and training in basic concepts of workers' compensation, the role of the treating physician, the conduct of permanent and stationary evaluations, and report writing.~~

~~(d) The amendment made to this section by SB 228 of the 2003–04 Regular Session shall not constitute good cause to reopen or rescind, alter, or amend any order, decision, or award of the appeals board.~~

SEC. 23. Section 4600 of the Labor Code is amended to read:

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

(b) As used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27 or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines.

(c) Unless the employer or the employer's insurer has established a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. ~~However, if an employee has notified his or her~~

~~employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury. If an employee requests a change of physician pursuant to Section 4601, the request may be made at any time after the injury, and the alternative physician, chiropractor, or acupuncturist shall be provided within five days of the request as required by Section 4601. For the purpose of this section, "personal physician" means the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history.~~

~~Where~~

(d) (1) If an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if either of the following conditions exist:

(A) The employer provides nonoccupational group health coverage in a health care service plan, licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(B) The employer provides nonoccupational health coverage in a group health plan or a group health insurance policy as described in Section 4616.7.

(2) For purposes of paragraph (1), a personal physician shall meet all of the following conditions:

(A) The physician is the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(B) The physician is the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history.

(C) The physician agrees to be predesignated.

(3) If the employer provides nonoccupational health care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the employer is notified pursuant to paragraph (1), all medical treatment,

utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code. Disputes regarding the provision of medical treatment shall be resolved pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(4) If the employer provides nonoccupational health care, as described in Section 4616.7, all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by the applicable provisions of the Insurance Code.

(5) The insurer may require prior authorization of any nonemergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to Section 4610.

(6) The maximum percentage of all employees who are covered under paragraph (1) that may be predesignated at any time in the state is 7 percent.

(7) If any court finds that any portion of this subdivision is invalid or in violation of any state or federal law, then this subdivision shall be inoperative.

(8) The division shall conduct an evaluation of this program and present its findings to the Governor and the Legislature on or before March 1, 2006.

(9) This subdivision shall remain in effect only until April 30, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before April 30, 2007, deletes or extends that date.

(e) (1) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation *administrative law* judge, the employee submits to examination by a physician, he or she shall be entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination. ~~Regardless~~

(2) Regardless of the date of injury, ''reasonable expenses of transportation'' includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of

the Department of Personnel Administration pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination.

~~Where~~

(f) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, *or* a workers' compensation *administrative law* judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, ''qualified interpreter'' means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

SEC. 24. Section 4603.2 of the Labor Code is amended to read:

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

(b) (1) Except as provided in subdivision (d) of Section 4603.4*, or under contracts authorized under Section 5307.11*, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made *at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service. Payments shall be made* by the employer within 45 working days after receipt of each separate, ~~itemized billing~~ *itemization of medical services provided*, together with any required reports and any written authorization for services that may have been received by the physician. If the ~~billing~~ *itemization* or a portion thereof is contested, denied, or considered incomplete,

the physician shall be notified, in writing, that the ~~billing~~ *itemization* is contested, denied, or considered incomplete, within 30 working days after receipt of the ~~billing~~ *itemization* by the employer. A notice that ~~a billing~~ *an itemization* is incomplete shall state all additional information required to make a decision. Any properly documented ~~amount~~ *list of services provided* not paid *at the rates then in effect under Section 5307.1* within the 45-working-day period shall be increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the ~~bill~~ *itemization*, unless the employer does both of the following:

(A) Pays the ~~uncontested amount~~ *provider at the rates in effect* within the 45-working-day period.

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

If an employer contests all or part of ~~a billing~~ *an itemization*, any amount determined payable by the appeals board shall carry interest from the date the amount was due until it is paid. If any contested ~~amount~~ *itemization* is determined payable by the appeals board, the defendant shall be ordered to reimburse the provider for any filing fees paid pursuant to Section 4903.05.

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

(2) Notwithstanding paragraph (1), if the employer is a governmental entity, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made within 60 working days after receipt of each separate~~, itemized billing~~ *itemization*, together with any required reports and any written authorization for services that may have been received by the physician.

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

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of ~~a billing~~ *an itemization* submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that ~~billing~~ *itemization* by the physician or medical provider. When an individual or entity conducting a ~~bill~~ *itemization* review determines that additional information or documentation is necessary to review the ~~billing~~ *itemization*, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing ~~a bill~~ *an itemization of service* submitted by a physician or medical provider shall not alter the procedure codes ~~billed~~ *listed* or recommend reduction of the amount of the ~~bill~~ *payment* unless the documentation submitted by the physician or medical provider with the ~~bill~~ *itemization of service* has been reviewed by that individual or entity. If the reviewer does not recommend payment *for services* as ~~billed~~ *itemized* by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or ~~amount billed~~ *changed other parts of the itemization* and the specific deficiency in the ~~billing~~ *itemization* or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

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

SEC. 25. Section 4604.5 of the Labor Code is amended to read:

4604.5. (a) Upon adoption by the administrative director of a medical treatment utilization schedule pursuant to Section

5307.27, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the *scientific medical* evidence establishing that a variance from the guidelines is reasonably required to cure ~~and~~ *or* relieve the ~~employee~~ *injured worker* from the effects of his or her injury. *The presumption created is one affecting the burden of proof.*

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices ~~as generally accepted by the health care community, and shall apply the current standards of care, including, but not limited to, appropriate and inappropriate diagnostic techniques, treatment modalities, adjustive modalities, length of treatment, and appropriate specialty referrals. These guidelines shall be educational and designed to assist providers by offering an analytical framework for the evaluation and treatment of the more common problems of injured workers, and shall assure appropriate and necessary care for all injured workers diagnosed with industrial conditions.~~ *that are evidence and scientifically based, nationally recognized, and peer-reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.*

(c) Three months after the publication date of the updated American College of Occupational and Environmental ~~Medicine~~ *Medicine's* Occupational ~~Medical~~ *Medicine* Practice Guidelines, and continuing until the effective date of a medical treatment utilization schedule, pursuant to Section 5307.27, the recommended guidelines set forth in the American College of Occupational and Environmental ~~Medical~~ *Medicine's Occupational Medicine* Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment*, regardless of date of injury.* The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury*, in accordance with Section 4600. The presumption created is one affecting the burden of proof.*

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

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

~~(f)~~

(2) This ~~section~~ *subdivision* shall not apply when an ~~insurance carrier~~ *employer* authorizes, in writing, additional visits to a health care practitioner for physical medicine services.

~~(g)~~

(e) For all injuries not covered by the American College of Occupational and Environmental ~~Medicine~~ *Medicine's* Occupational Medicine Practice Guidelines or official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the *national* medical community *and that are scientifically based.*

SEC. 27. Article 2.3 (commencing with Section 4616) is added to Chapter 2 of Part 2 of Division 4 of the Labor Code, to read:

Article 2.3. Medical Provider Networks

4616. (a) (1) On or after January 1, 2005, an insurer or employer may establish or modify a medical provider network for the provision of medical treatment to injured employees. The network shall include physicians primarily engaged in the treatment of occupational injuries and physicians primarily engaged in the treatment of nonoccupational injuries. The goal shall be at least 25 percent of physicians primarily engaged in the treatment of nonoccupational injuries. The administrative director shall encourage the integration of occupational and nonoccupational providers. The number of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. The

provider network shall include an adequate number and type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed.

(2) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees. With respect to availability and accessibility of treatment, the administrative director shall consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart.

(b) The employer or insurer shall submit a plan for the medical provider network to the administrative director for approval. The administrative director shall approve the plan if he or she determines that the plan meets the requirements of this section. If the administrative director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved.

(c) Physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment.

(d) If the employer or insurer meets the requirements of this section, the administrative director may not withhold approval or disapprove an employer's or insurer's medical provider network based solely on the selection of providers. In developing a medical provider network, an employer or insurer shall have the exclusive right to determine the members of their network.

(e) All treatment provided shall be provided in accordance with the medical treatment utilization schedule established pursuant to Section 5307.27 or the American College of Occupational Medicine's Occupational Medicine Practice Guidelines, as appropriate.

(f) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment.

(g) On or before November 1, 2004, the administrative director, in consultation with the Department of Managed Health Care,

shall adopt regulations implementing this article. The administrative director shall develop regulations that establish procedures for purposes of making medical provider network modifications.

4616.1. (a) An insurer or employer that offers a medical provider network under this division and that uses economic profiling shall file with the administrative director a description of any policies and procedures related to economic profiling utilized by the insurer or employer. The filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, and in provider retention and termination decisions. The insurer or employer shall provide a copy of the filing to an individual physician, provider, medical group, or individual practice association.

(b) The administrative director shall make each insurer's or employer's filing available to the public upon request. The administrative director may not publicly disclose any information submitted pursuant to this section that is determined by the administrative director to be confidential pursuant to state or federal law.

(c) For the purposes of this article, "economic profiling" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

4616.2. (a) An insurer or employer that arranges for care for injured employees through a medical provider network shall file a written continuity of care policy with the administrative director.

(b) If approved by the administrative director, the provisions of the written continuity of care policy shall replace all prior continuity of care policies. The insurer or employer shall file a revision of the continuity of care policy with the administrative director if it makes a material change to the policy.

(c) The insurer or employer shall provide to all employees entering the workers' compensation system notice of its written continuity of care policy and information regarding the process for an employee to request a review under the policy and shall provide, upon request, a copy of the written policy to an employee.

(d) (1) An insurer or employer that offers a medical provider network shall, at the request of an injured employee, provide the completion of treatment as set forth in this section by a terminated provider.

(2) The completion of treatment shall be provided by a terminated provider to an injured employee who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in paragraph (3).

(3) The insurer or employer shall provide for the completion of treatment for the following conditions subject to coverage through the workers' compensation system:

(A) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of treatment shall be provided for the duration of the acute condition.

(B) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the insurer or employer in consultation with the injured employee and the terminated provider and consistent with good professional practice. Completion of treatment under this paragraph shall not exceed 12 months from the contract termination date.

(C) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of treatment shall be provided for the duration of a terminal illness.

(D) Performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

(4) (A) The insurer or employer may require the terminated provider whose services are continued beyond the contract

termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer or employer is not required to continue the provider's services beyond the contract termination date.

(B) Unless otherwise agreed by the terminated provider and the insurer or employer, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the insurer or employer for currently contracting providers providing similar services who are practicing in the same or a similar geographic area as the terminated provider. The insurer or provider is not required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(5) An insurer or employer shall ensure that the requirements of this section are met.

(6) This section shall not require an insurer or employer to provide for completion of treatment by a provider whose contract with the insurer or employer has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

(7) Nothing in this section shall preclude an insurer or employer from providing continuity of care beyond the requirements of this section.

(e) The insurer or employer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer or employer is not required to continue the provider's services beyond the contract termination date.

4616.3. (a) When the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the employer shall arrange an initial medical evaluation and begin treatment as required by Section 4600.

(b) The employer shall notify the employee of his or her right to be treated by a physician of his or her choice after the first visit from the medical provider network established pursuant to this article, and the method by which the list of participating providers may be accessed by the employee.

(c) If an injured employee disputes either the diagnosis or the treatment prescribed by the treating physician, the employee may seek the opinion of another physician in the medical provider network. If the injured employee disputes the diagnosis or treatment prescribed by the second physician, the employee may seek the opinion of a third physician in the medical provider network.

(d) (1) Selection by the injured employee of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question.

(2) Treatment by a specialist who is not a member of the medical provider network may be permitted on a case-by-case basis if the medical provider network does not contain a physician who can provide the approved treatment and the treatment is approved by the employer or the insurer.

4616.4. (a) (1) The administrative director shall contract with individual physicians, as described in paragraph (2), or an independent medical review organization to perform independent medical reviews pursuant to this section.

(2) Only physicians licensed pursuant to Chapter 5 (commencing with Section 2000) of the Business and Professions Code may be independent medical reviewers.

(3) The administrative director shall ensure that the independent medical reviewers or those within the review organization shall do all of the following:

(A) Be appropriately credentialed and privileged.

(B) Ensure that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensure that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions consistent with the medical utilization schedule established pursuant to Section 5307.27, or

the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines.

(D) Ensure that confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensure the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensure adequate screening for conflicts of interest.

(4) Medical professionals selected by the administrative director or the independent medical review organizations to review medical treatment decisions shall be physicians, as specified in paragraph (2) of subdivision (a), who meet the following minimum requirements:

(A) The medical professional shall be a clinician knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) Notwithstanding any other provision of law, the medical professional shall hold a nonrestricted license in any state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions taken or pending by any hospital, government, or regulatory body.

(b) If, after the third physician's opinion, the treatment or diagnostic service remains disputed, the injured employee may request independent medical review regarding the disputed treatment or diagnostic service still in dispute after the third physician's opinion in accordance with Section 4616.3. The standard to be utilized for independent medical review is identical to that contained in the medical treatment utilization schedule established in Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, as appropriate.

(c) Applications for independent medical review shall be submitted to the administrative director on a one-page form

provided by the administrative director entitled "Independent Medical Review Application." The form shall contain a signed release from the injured employee, or a person authorized pursuant to law to act on behalf of the injured employee, authorizing the release of medical and treatment information. The injured employee may provide any relevant material or documentation with the application. The administrative director or the independent medical review organization shall assign the independent medical reviewer.

(d) Following receipt of the application for independent medical review, the employer or insurer shall provide the independent medical reviewer, assigned pursuant to subdivision (c), with all information that was considered in relation to the disputed treatment or diagnostic service, including both of the following:

(1) A copy of all correspondence from, and received by, any treating physician who provided a treatment or diagnostic service to the injured employee in connection with the injury.

(2) A complete and legible copy of all medical records and other information used by the physicians in making a decision regarding the disputed treatment or diagnostic service.

(e) Upon receipt of information and documents related to the application for independent medical review, the independent medical reviewer shall conduct a physical examination of the injured employee at the employee's discretion. The reviewer may order any diagnostic tests necessary to make his or her determination regarding medical treatment. Utilizing the medical treatment utilization schedule established pursuant to Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, as appropriate, and taking into account any reports and information provided, the reviewer shall determine whether the disputed health care service was consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines based on the specific medical needs of the injured employee.

(f) The independent medical reviewer shall issue a report to the administrative director, in writing, and in layperson's terms to the maximum extent practicable, containing his or her analysis and

determination whether the disputed health care service was consistent with the medical treatment utilization schedule established pursuant to Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, as appropriate, within 30 days of the examination of the injured employee, or within less time as prescribed by the administrative director. If the disputed health care service has not been provided and the independent medical reviewer certifies in writing that an imminent and serious threat to the health of the injured employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the injured employee, the report shall be expedited and rendered within three days of the examination by the independent medical reviewer. Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the administrative director for up to three days in extraordinary circumstances or for good cause.

(g) The independent medical reviewer's analysis shall cite the injured employee's medical condition, the relevant documents in the record, and the relevant findings associated with the documents or any other information submitted to the reviewer in order to support the determination.

(h) The administrative director shall immediately adopt the determination of the independent medical reviewer, and shall promptly issue a written decision to the parties.

(i) If the determination of the independent medical reviewer finds that the disputed treatment or diagnostic service is consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, the injured employee may seek the disputed treatment or diagnostic service from a physician of his or her choice from within or outside the medical provider network. Treatment outside the medical provider network shall be provided consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Practice Guidelines. The employer shall be liable for the cost of any approved medical treatment in accordance with Section 5307.1 or 5307.11.

4616.5. For purposes of this article, "employer" means a self-insured employer, joint powers authority, or the state.

4616.6. No additional examinations shall be ordered by the appeals board and no other reports shall be admissable to resolve any controversy arising out of this article.

4616.7. (a) A health care organization certified pursuant to Section 4600.5 shall be deemed approved pursuant to this article if it meets the percentage required for physicians primarily engaged in nonoccupational medicine specified in subdivision (a) of Section 4616 and all the other requirements of this article are met, as determined by the administrative director.

(b) A health care service plan, licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, shall be deemed approved for purposes of this article if it has a reasonable number of physicians with competency in occupational medicine, as determined by the administrative director.

(c) A group disability insurance policy, as defined in subdivision (b) of Section 106 of the Insurance Code, that covers hospital, surgical, and medical care expenses shall be deemed approved for purposes of this article if it has a reasonable number of physicians with competency in occupational medicine, as determined by the administrative director. For the purposes of this section, a group disability insurance policy shall not include Medicare supplement, vision-only, dental-only, and Champus-supplement insurance. For purposes of this section, a group disability insurance policy shall not include hospital indemnity, accident-only, and specified disease insurance that pays benefits on a fixed benefit, cash-payment-only basis.

(d) Any Taft-Hartley health and welfare fund shall be deemed approved for purposes of this article if it has a reasonable number of physicians with competency in occupational medicine, as determined by the administrative director.

SEC. 28. Section 4650 of the Labor Code is amended to read:

4650. (a) If an injury causes temporary disability, the first payment of temporary disability indemnity shall be made not later than 14 days after knowledge of the injury and disability, on which date all indemnity then due shall be paid, unless liability for the injury is earlier denied.

(b) If the injury causes permanent disability, the first payment shall be made within 14 days after the date of last payment of temporary disability indemnity. ~~Where~~ *When the last payment of temporary disability indemnity has been made pursuant to subdivision (c) of Section 4656, and regardless of whether* the extent of permanent disability ~~cannot~~ *can* be determined at ~~the~~ *that* date~~ of last payment of temporary disability indemnity~~, the employer nevertheless shall commence the timely payment required by this subdivision and shall continue to make these payments until the employer's reasonable estimate of permanent disability indemnity due has been paid, and if the amount of permanent disability indemnity due has been determined, until that amount has been paid.

(c) Payment of temporary or permanent disability indemnity subsequent to the first payment shall be made as due every two weeks on the day designated with the first payment.

(d) If any indemnity payment is not made timely as required by this section, the amount of the late payment shall be increased 10 percent and shall be paid, without application, to the employee, unless the employer continues the employee's wages under a salary continuation plan, as defined in subdivision (g). No increase shall apply to any payment due prior to or within 14 days after the date the claim form was submitted to the employer under Section 5401. No increase shall apply when, within the 14-day period specified under subdivision (a), the employer is unable to determine whether temporary disability indemnity payments are owed and advises the employee, in the manner prescribed in rules and regulations adopted pursuant to Section 138.4, why payments cannot be made within the 14-day period, what additional information is required to make the decision whether temporary disability indemnity payments are owed, and when the employer expects to have the information required to make the decision.

(e) If the employer is insured for its obligation to provide compensation, the employer shall be obligated to reimburse the insurer for the amount of increase in indemnity payments, made pursuant to subdivision (d), if the late payment which gives rise to the increase in indemnity payments, is due less than seven days after the insurer receives the completed claim form from the employer. Except as specified in this subdivision, an employer shall not be obligated to reimburse an insurer nor shall an insurer

be permitted to seek reimbursement, directly or indirectly, for the amount of increase in indemnity payments specified in this section.

(f) If an employer is obligated under subdivision (e) to reimburse the insurer for the amount of increase in indemnity payments, the insurer shall notify the employer in writing, within 30 days of the payment, that the employer is obligated to reimburse the insurer and shall bill and collect the amount of the payment no later than at final audit. However, the insurer shall not be obligated to collect, and the employer shall not be obligated to reimburse, amounts paid pursuant to subdivision (d) unless the aggregate total paid in a policy year exceeds one hundred dollars ($100). The employer shall have 60 days, following notice of the obligation to reimburse, to appeal the decision of the insurer to the Department of Insurance. The notice of the obligation to reimburse shall specify that the employer has the right to appeal the decision of the insurer as provided in this subdivision.

(g) For purposes of this section, ''salary continuation plan'' means a plan ~~which~~ *that* meets both of the following requirements:

(1) The plan is paid for by the employer pursuant to statute, collective bargaining agreement, memorandum of understanding, or established employer policy.

(2) The plan provides the employee on his or her regular payday with salary not less than the employee is entitled to receive pursuant to statute, collective bargaining agreement, memorandum of understanding, or established employer policy and not less than the employee would otherwise receive in indemnity payments.

SEC. 29. Section 4656 of the Labor Code is amended to read:

4656. *(a)* Aggregate disability payments for a single injury occurring prior to January 1, 1979, causing temporary disability shall not extend for more than 240 compensable weeks within a period of five years from the date of the injury.

~~Aggregate~~

(b) Aggregate disability payments for a single injury occurring on or after January 1, 1979, *and prior to the effective date of subdivision (c),* causing temporary partial disability shall not extend for more than 240 compensable weeks within a period of five years from the date of the injury.

(c) (1) Aggregate disability payments for a single injury occurring on or after the effective date of this subdivision, causing temporary disability shall not extend for more than 104 compensable weeks within a period of two years from the date of commencement of temporary disability payment.

(2) Notwithstanding paragraph (1), for an employee who suffers from the following injuries or conditions, aggregate disability payments for a single injury occurring on or after the effective date of this subdivision, causing temporary disability shall not extend for more than 240 compensable weeks within a period of five years from the date of the injury:

(A) Acute and chronic hepatitis B.

(B) Acute and chronic hepatitis C.

(C) Amputations.

(D) Severe burns.

(E) Human immunodeficiency virus (HIV).

(F) High-velocity eye injuries.

(G) Chemical burns to the eyes.

(H) Pulmonary fibrosis.

(I) Chronic lung disease.

SEC. 30. Section 4658 of the Labor Code is amended to read:

4658. (a) For injuries occurring prior to January 1, 1992, if the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed, according to paragraph (1). However, in no event shall the disability payment allowed be less than the disability payment computed according to paragraph (2).

(1)

Column 1—Range of percentage of permanent 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:
Under 10	3
10–19.75	4
20–29.75	5
30–49.75	6

50–69.75	7
70–99.75	8

The number of weeks for which payments shall be allowed set forth in column 2 above based upon the percentage of permanent disability set forth in column 1 above shall be cumulative, and the number of benefit weeks shall increase with the severity of the disability. The following schedule is illustrative of the computation of the number of benefit weeks:

Column 1—Percentage of permanent disability incurred:	Column 2—Cumulative number of benefit weeks:
5	15.00
10	30.25
15	50.25
20	70.50
25	95.50
30	120.75
35	150.75
40	180.75
45	210.75
50	241.00
55	276.00
60	311.00
65	346.00
70	381.25
75	421.25
80	461.25
85	501.25
90	541.25
95	581.25
100	for life

(2) Two-thirds of the average weekly earnings for four weeks for each 1 percent of disability, where, for the purposes of this subdivision, the average weekly earnings shall be taken at not more than seventy-eight dollars and seventy-five cents ($78.75).

(b) This subdivision shall apply to injuries occurring on or after January 1, 1992. If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed, according to paragraph (1). However, in no event shall the disability payment allowed be less than the disability payment computed according to paragraph (2).

(1)

Column 1—Range of percentage of permanent 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:
Under 10	3
10–19.75	4
20–24.75	5
25–29.75	6
30–49.75	7
50–69.75	8
70–99.75	9

The numbers set forth in column 2 above are based upon the percentage of permanent disability set forth in column 1 above and shall be cumulative, and shall increase with the severity of the disability in the manner illustrated in subdivision (a).

(2) Two-thirds of the average weekly earnings for four weeks for each 1 percent of disability, where, for the purposes of this subdivision, the average weekly earnings shall be taken at not more than seventy-eight dollars and seventy-five cents ($78.75).

(c) This subdivision shall apply to injuries occurring on or after January 1, 2004. If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed as follows:

Column 1—Range of percentage of permanent 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:
Under 10	4
10–19.75	5
20–24.75	5
25–29.75	6
30–49.75	7
50–69.75	8
70–99.75	9

The numbers set forth in column 2 above are based upon the percentage of permanent disability set forth in column 1 above and shall be cumulative, and shall increase with the severity of the disability in the manner illustrated in subdivision (a).

(d) (1) This subdivision shall apply to injuries occurring on or after the effective date of the revised permanent disability schedule adopted by the administrative director pursuant to Section 4660. If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the basic disability payment computed as follows:

Column 1—Range of percentage of permanent 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:*
0.25–9.75	*3*
10–14.75	*4*
15–24.75	*5*
25–29.75	*6*
30–49.75	*7*
50–69.75	*8*
70–99.75	*16*

The numbers set forth in column 2 above are based upon the percentage of permanent disability set forth in column 1 above and shall be cumulative, and shall increase with the severity of the disability in the manner illustrated in subdivision (a).

(2) If, within 60 days of a disability becoming permanent and stationary, an employer does not offer the injured employee regular work, modified work, or alternative work, in the form and manner prescribed by the administrative director, for a period of at least 12 months, each disability payment remaining to be paid to the injured employee from the date of the end of the 60-day period shall be paid in accordance with paragraph (1) and increased by 15 percent. This paragraph shall not apply to an employer that employs fewer than 50 employees.

(3) (A) If, within 60 days of a disability becoming permanent and stationary, an employer offers the injured employee regular work, modified work, or alternative work, in the form and manner prescribed by the administrative director, for a period of at least 12 months, and regardless of whether the injured employee accepts or rejects the offer, each disability payment remaining to be paid to the injured employee from the date the offer was made shall be paid in accordance with paragraph (1) and decreased by 15 percent.

(B) If the regular work, modified work, or alternative work is terminated by the employer before the end of the period for which disability payments are due the injured employee, the amount of each of the remaining disability payments shall be paid in accordance with paragraph (1) and increased by 15 percent. An employee who voluntarily terminates employment shall not be eligible for payment under this subparagraph. This paragraph shall not apply to an employer that employs fewer than 50 employees.

(4) For compensable claims arising before April 30, 2004, the schedule provided in this subdivision shall not apply to the determination of permanent disabilities when there has been either a comprehensive medical-legal report or a report by a treating physician, indicating the existence of permanent disability, or when the employer is required to provide the notice required by Section 4061 to the injured worker.

SEC. 31. Section 4658.1 is added to the Labor Code, to read:

4658.1. As used in this article, the following definitions apply:

(a) "Regular work" means the employee's usual occupation or the position in which the employee was engaged at the time of injury and that offers wages and compensation equivalent to those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

(b) "Modified work" means regular work modified so that the employee has the ability to perform all the functions of the job and that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

(c) "Alternative work" means work that the employee has the ability to perform, that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and that is located within reasonable commuting distance of the employee's residence at the time of injury.

(d) For the purpose of determining whether wages and compensation are equivalent to those paid at the time of injury, the wages and compensation for any increase in working hours over the average hours worked at the time of injury shall not be considered.

(e) For the purpose of determining whether wages and compensation are equivalent to those paid at the time of injury, actual wages and compensation shall be determined without regard to the minimums and maximums set forth in Chapter 1 (commencing with Section 4451).

(f) The condition that regular work, modified work, or alternative work be located within a reasonable distance of the employee's residence at the time of injury may be waived by the employee. The condition shall be deemed to be waived if the employee accepts the regular work, modified work, or alternative work and does not object to the location within 20 days of being informed of the right to object. The condition shall be conclusively deemed to be satisfied if the offered work is at the same location and the same shift as the employment at the time of injury.

SEC. 32. Section 4660 of the Labor Code is amended to read:

4660. (a) In determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee,

and his *or her* age at the time of ~~such~~ *the* injury, consideration being given to ~~the~~ *an employee's* diminished ~~ability of such injured employee to compete in an open labor market~~ *future earning capacity.*

(b) *(1) For purposes of this section, the "nature of the physical injury or disfigurement" shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition).*

(2) For purposes of this section, an employee's diminished future earning capacity shall be a numeric formula based on empirical data and findings that aggregate the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees. The administrative director shall formulate the adjusted rating schedule based on empirical data and findings from the Evaluation of California's Permanent Disability Rating Schedule, Interim Report (December 2003), prepared by the RAND Institute for Civil Justice, and upon data from additional empirical studies.

(c) The administrative director ~~may prepare, adopt, and from time to time~~ *shall* amend~~, a~~ *the* schedule for the determination of the percentage of permanent ~~disabilities~~ *disability* in accordance with this section *at least once every five years*. ~~Such~~ *This* schedule shall be available for public inspection~~,~~ and, without formal introduction in evidence, shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule.

~~(c) Any such~~

(d) The schedule shall promote consistency, uniformity, and objectivity. The schedule and any amendment thereto or revision thereof shall apply prospectively and shall apply to and govern only those permanent disabilities ~~which~~ *that* result from compensable injuries received or occurring on and after the effective date of the adoption of ~~such~~ *the* schedule, amendment or revision, as the fact may ~~be~~ *be. For compensable claims arising before January 1, 2005, the schedule as revised pursuant to changes made in legislation enacted during the 2003–04 Regular and Extraordinary Sessions shall apply to the determination of permanent disabilities when there has been either no*

comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by Section 4061 to the injured worker.

~~(d) On or before January 1, 1995, the administrative director shall review and revise the schedule for the determination of the percentage of permanent disabilities. The revision shall include, but not be limited to, an updating of the standard disability ratings and occupations to reflect the current labor market. However, no change in standard disability ratings shall be adopted without the approval of the Commission of Health and Safety and Workers' Compensation. A proposed revision shall be submitted to the commission on or before July 1, 1994.~~

(e) On or before January 1, 2005, the administrative director shall adopt regulations to implement the changes made to this section by the act that added this subdivision.

SEC. 33. Section 4663 of the Labor Code is repealed.

~~4663. In case of aggravation of any disease existing prior to a compensable injury, compensation shall be allowed only for the proportion of the disability due to the aggravation of such prior disease which is reasonably attributed to the injury.~~

SEC. 34. Section 4663 is added to the Labor Code, to read:

4663. (a) Apportionment of permanent disability shall be based on causation.

(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that

prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

SEC. 35. Section 4664 is added to the Labor Code, to read:

4664. (a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

(c) (1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

(A) Hearing.

(B) Vision.

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders.

(F) The lower extremities, including the hip joints.

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

SEC. 36. Section 4706.5 of the Labor Code is amended to read:

4706.5. (a) Whenever any fatal injury is suffered by an employee under ~~such~~ circumstances ~~as to~~ *that would* entitle the employee to compensation benefits, but for his or her death, and the employee does not leave surviving any person entitled to a dependency death benefit, the employer shall pay a sum to the Department of Industrial Relations equal to the total dependency death benefit that would be payable to a surviving spouse with no dependent minor children.

(b) ~~Where~~ *When* the deceased employee leaves no surviving dependent, personal representative, heir, or other person entitled to the accrued and unpaid compensation referred to in Section 4700, the accrued and unpaid compensation shall be paid by the employer to the Department of Industrial Relations.

(c) The payments to be made to the Department of Industrial Relations, as required by subdivisions (a) and (b), shall be deposited in the General Fund and shall be credited, as a reimbursement, to any appropriation to the Department of Industrial Relations for payment of the additional compensation for subsequent injury provided in Article 5 (commencing with Section ~~4750)~~ *4751)*, in the fiscal year in which the Controller's receipt is issued.

(d) The payments to be made to the Department of Industrial Relations, as required by subdivision (a), shall be paid to the department in a lump sum in the manner provided in subdivision (b) of Section 5101.

(e) The Department of Industrial Relations shall keep a record of all payments due the state under this section, and shall take ~~such~~ *any* steps as may be necessary to collect those amounts.

(f) Each employer, or the employer's insurance carrier, shall notify the administrative director, in ~~such~~ *any* form as the administrative director may prescribe, of each employee death, except when the employer has actual knowledge or notice that the deceased employee left a surviving dependent.

(g) When, after a reasonable search, the employer concludes that the deceased employee left no one surviving who is entitled to a dependency death benefit, and concludes that the death was under ~~such~~ circumstances ~~as to~~ *that would* entitle the employee to compensation benefits, the employer may voluntarily make the payment referred to in subdivision (a). Payments so made shall be construed as payments made pursuant to an appeals board findings

and award. Thereafter, if the appeals board finds that the deceased employee did in fact leave a person surviving who is entitled to a dependency death benefit, upon that finding, all payments referred to in subdivision (a) ~~which~~ *that* have been made shall be forthwith returned to the employer, or if insured, to the employer's workers' compensation carrier that indemnified the employer for the loss.

SEC. 37. Section 4750 of the Labor Code is repealed.

~~4750. An employee who is suffering from a previous permanent disability or physical impairment and sustains permanent injury thereafter shall not receive from the employer compensation for the later injury in excess of the compensation allowed for such injury when considered by itself and not in conjunction with or in relation to the previous disability or impairment.~~

~~The employer shall not be liable for compensation to such an employee for the combined disability, but only for that portion due to the later injury as though no prior disability or impairment had existed.~~

SEC. 38. Section 4750.5 of the Labor Code is repealed.

~~4750.5. An employee who has sustained a compensable injury and who subsequently sustains an unrelated noncompensable injury, shall not receive permanent disability indemnity for any permanent disability caused solely by the subsequent noncompensable injury.~~

~~The purpose of this section is to overrule the decision in Jensen v. WCAB, 136 Cal. App. 3d 1042.~~

SEC. 39. Section 4903.05 of the Labor Code is amended to read:

4903.05. (a) A filing fee of one hundred dollars ($100) shall be charged for each initial lien filed by providers*, or on behalf of providers*, pursuant to subdivision (b) of Section 4903.

(b) No filing fee shall be required for liens filed by the Veterans Administration, the Medi-Cal program, or public hospitals.

(c) The filing fee shall be collected by the court administrator. All fees shall be deposited in the Workers' Compensation Administration Revolving Fund. Any fees collected from providers that have not been redistributed to providers pursuant to paragraph (2) of subdivision (b) of Section 4603.2, shall be used to offset the amount of fees assessed on employers under Section 62.5.

(d) The court administrator shall adopt reasonable rules and regulations governing the procedures for the collection of the filing fee.

SEC. 40. Section 5402 of the Labor Code is amended to read:

5402. (a) Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.

(b) If liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period.

(c) Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment, consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

(d) Treatment provided under subdivision (c) shall not give rise to a presumption of liability on the part of the employer.

SEC. 41. Section 5703 of the Labor Code is amended to read:

5703. The appeals board may receive as evidence either at or subsequent to a hearing, and use as proof of any fact in dispute, the following matters, in addition to sworn testimony presented in open hearing:

(a) Reports of attending or examining physicians.

(1) Statements concerning any bill for services are admissible only if made under penalty of perjury that they are true and correct to the best knowledge of the physician.

(2) In addition, reports are admissible under this subdivision only if the physician has further stated in the body of the report that there has not been a violation of Section 139.3 and that the contents of the report are true and correct to the best knowledge of the physician. The statement shall be made under penalty of perjury.

(b) Reports of special investigators appointed by the appeals board or a workers' compensation judge to investigate and report upon any scientific or medical question.

(c) Reports of employers, containing copies of timesheets, book accounts, reports, and other records properly authenticated.

(d) Properly authenticated copies of hospital records of the case of the injured employee.

(e) All publications of the Division of Workers' Compensation.

(f) All official publications of the State of California and United States governments.

(g) Excerpts from expert testimony received by the appeals board upon similar issues of scientific fact in other cases and the prior decisions of the appeals board upon similar issues.

(h) Relevant portions of medical treatment protocols published by medical specialty societies. To be admissible, the party offering such a protocol or portion of a protocol shall concurrently enter into evidence information regarding how the protocol was developed, and to what extent the protocol is evidence-based, peer-reviewed, and nationally recognized~~, as required by regulations adopted by the appeals board~~. If a party offers into evidence a portion of a treatment protocol, any other party may offer into evidence additional portions of the protocol. The party offering a protocol, or portion thereof, into evidence shall either make a printed copy of the full protocol available for review and copying, or shall provide an Internet address at which the entire protocol may be accessed without charge.

(i) The medical treatment utilization schedule in effect pursuant to Section 5307.27 or the guidelines in effect pursuant to Section 4604.5.

SEC. 42. Section 5814 of the Labor Code is amended to read:

5814. *(a)* When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the full amount of the order, decision, or award shall be increased by 10 percent. Multiple increases shall not be awarded for repeated delays in making a series of payments due for the same type or specie of benefit unless there has been a legally significant event between the delay and the subsequent delay in payments of the same type or specie of benefits. The question of delay and the reasonableness of the cause therefor shall be determined by the appeals board in accordance with the facts.

This delay or refusal shall constitute good cause under Section 5803 to rescind, alter, or amend the order, decision, or award for the purpose of making the increase provided for herein.

(b) This section shall become inoperative on June 1, 2004, and, as of January 1, 2005, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2005, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 43. Section 5814 is added to the Labor Code, to read:

5814. (a) When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the amount of the payment unreasonably delayed or refused shall be increased up to 25 percent or up to ten thousand dollars ($10,000), whichever is less. In any proceeding under this section, the appeals board shall use its discretion to accomplish a fair balance and substantial justice between the parties.

(b) If a potential violation of this section is discovered by the employer prior to an employee claiming a penalty under this section, the employer, within 90 days of the date of the discovery, may pay a self-imposed penalty in the amount of 10 percent of the amount of the payment unreasonably delayed or refused, along with the amount of the payment delayed or refused. This self-imposed penalty shall be in lieu of the penalty in subdivision (a).

(c) Upon the approval of a compromise and release, findings and awards, or stipulations and orders by the appeals board, it shall be conclusively presumed that any accrued claims for penalty have been resolved, regardless of whether a petition for penalty has been filed, unless the claim for penalty is expressly excluded by the terms of the order or award. Upon the submission of any issue for determination at a regular trial hearing, it shall be conclusively presumed that any accrued claim for penalty in connection with the benefit at issue has been resolved, regardless of whether a petition for penalty has been filed, unless the issue of penalty is also submitted or is expressly excluded in the statement of issues being submitted.

(d) The payment of any increased award pursuant to subdivision (a) shall be reduced by any amount paid under subdivision (d) of Section 4650 on the same unreasonably delayed or refused benefit payment.

(e) No unreasonable delay in the provision of medical treatment shall be found when the treatment has been authorized by the employer in a timely manner and the only dispute concerns payment of a billing submitted by a physician or medical provider as provided in Section 4603.2.

(f) Nothing in this section shall be construed to create a civil cause of action.

(g) Notwithstanding any other provision of law, no action may be brought to recover penalties that may be awarded under this section more than two years from the date the payment of compensation was due.

(h) This section shall apply to all injuries, without regard to whether the injury occurs before, on, or after the operative date of this section.

(i) This section shall become operative on June 1, 2004.

SEC. 44. Section 5814.6 is added to the Labor Code, to read:

5814.6. (a) Any employer or insurer that knowingly violates Section 5814 with a frequency that indicates a general business practice is liable for administrative penalties of not to exceed four hundred thousand dollars ($400,000). Penalty payments shall be imposed by the administrative director and deposited into the Return-to-Work Fund established pursuant to Section 139.48.

(b) The administrative director may impose a penalty under either this section or subdivision (e) of Section 129.5.

(c) This section shall become operative on June 1, 2004.

SEC. 45. Section 6401.7 of the Labor Code is amended to read:

6401.7. (a) Every employer shall establish, implement, and maintain an effective injury prevention program. The program shall be written, except as provided in subdivision (e), and shall include, but not be limited to, the following elements:

(1) Identification of the person or persons responsible for implementing the program.

(2) The employer's system for identifying and evaluating workplace hazards, including scheduled periodic inspections to identify unsafe conditions and work practices.

(3) The employer's methods and procedures for correcting unsafe or unhealthy conditions and work practices in a timely manner.

(4) An occupational health and safety training program designed to instruct employees in general safe and healthy work practices and to provide specific instruction with respect to hazards specific to each employee's job assignment.

(5) The employer's system for communicating with employees on occupational health and safety matters, including provisions designed to encourage employees to inform the employer of hazards at the worksite without fear of reprisal.

(6) The employer's system for ensuring that employees comply with safe and healthy work practices, which may include disciplinary action.

(b) The employer shall correct unsafe and unhealthy conditions and work practices in a timely manner based on the severity of the hazard.

(c) The employer shall train all employees when the training program is first established, all new employees, and all employees given a new job assignment, and shall train employees whenever new substances, processes, procedures, or equipment are introduced to the workplace and represent a new hazard, and whenever the employer receives notification of a new or previously unrecognized hazard. Beginning January 1, 1994, an employer in the construction industry who is required to be licensed under Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code may use employee training provided to the employer's employees under a construction industry occupational safety and health training program approved by the division to comply with the requirements of subdivision (a) relating to employee training, and shall only be required to provide training on hazards specific to an employee's job duties.

(d) The employer shall keep appropriate records of steps taken to implement and maintain the program. Beginning January 1, 1994, an employer in the construction industry who is required to be licensed under Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code may use records relating to employee training provided to the employer in connection with an occupational safety and health training program approved by the division to comply with the requirements of this subdivision, and shall only be required to keep records of

those steps taken to implement and maintain the program with respect to hazards specific to an employee's job duties.

(e) (1) The standards board shall adopt a standard setting forth the employer's duties under this section, on or before January 1, 1991, consistent with the requirements specified in subdivisions (a), (b), (c), and (d). The standards board, in adopting the standard, shall include substantial compliance criteria for use in evaluating an employer's injury prevention program. The board may adopt less stringent criteria for employers with few employees and for employers in industries with insignificant occupational safety or health hazards.

(2) Notwithstanding subdivision (a), for employers with fewer than 20 employees who are in industries that are not on a designated list of high hazard industries and who have a workers' compensation experience modification rate of 1.1 or less, and for any employers with fewer than 20 employees who are in industries that are on a designated list of low hazard industries, the board shall adopt a standard setting forth the employer's duties under this section consistent with the requirements specified in subdivisions (a), (b), and (c), except that the standard shall only require written documentation to the extent of documenting the person or persons responsible for implementing the program pursuant to paragraph (1) of subdivision (a), keeping a record of periodic inspections pursuant to paragraph (2) of subdivision (a), and keeping a record of employee training pursuant to paragraph (4) of subdivision (a). To any extent beyond the specifications of this subdivision, the standard shall not require the employer to keep the records specified in subdivision (d).

(3) The division shall establish a list of high hazard industries using the methods prescribed in Section 6314.1 for identifying and targeting employers in high hazard industries. For purposes of this subdivision, the ''designated list of high hazard industries'' shall be the list established pursuant to this paragraph.

For the purpose of implementing this subdivision, the Department of Industrial Relations shall periodically review, and as necessary revise, the list.

(4) For the purpose of implementing this subdivision, the Department of Industrial Relations shall also establish a list of low hazard industries, and shall periodically review, and as necessary revise, that list.

(f) The standard adopted pursuant to subdivision (e) shall specifically permit employer and employee occupational safety and health committees to be included in the employer's injury prevention program. The board shall establish criteria for use in evaluating employer and employee occupational safety and health committees. The criteria shall include minimum duties, including the following:

(1) Review of the employer's (A) periodic, scheduled worksite inspections, (B) investigation of causes of incidents resulting in injury, illness, or exposure to hazardous substances, and (C) investigation of any alleged hazardous condition brought to the attention of any committee member. When determined necessary by the committee, the committee may conduct its own inspections and investigations.

(2) Upon request from the division, verification of abatement action taken by the employer as specified in division citations.

If an employer's occupational safety and health committee meets the criteria established by the board, it shall be presumed to be in substantial compliance with paragraph (5) of subdivision (a).

(g) The division shall adopt regulations specifying the procedures for selecting employee representatives for employer-employee occupational health and safety committees when these procedures are not specified in an applicable collective bargaining agreement. No employee or employee organization shall be held liable for any act or omission in connection with a health and safety committee.

(h) The employer's injury prevention program, as required by this section, shall cover all of the employer's employees and all other workers who the employer controls or directs and directly supervises on the job to the extent these workers are exposed to worksite and job assignment specific hazards. Nothing in this subdivision shall affect the obligations of a contractor or other employer ~~which~~ *that* controls or directs and directly supervises its own employees on the job.

(i) ~~Where~~ *When* a contractor supplies its employee to a state agency employer on a temporary basis, the state agency employer may assess a fee upon the contractor to reimburse the state agency for the additional costs, if any, of including the contract employee within the state agency's injury prevention program.

(j) (1) The division shall prepare a Model Injury and Illness Prevention Program for Non-High-Hazard Employment, and shall make copies of the model program prepared pursuant to this subdivision available to employers, upon request, for posting in the workplace. An employer who adopts and implements the model program prepared by the division pursuant to this paragraph in good faith shall not be assessed a civil penalty for the first citation for a violation of this section issued after the employer's adoption and implementation of the model program.

(2) For purposes of this subdivision, the division shall establish a list of non-high-hazard industries in California~~, that may include the industries that, pursuant to Section 14316 of Title 8 of the California Code of Regulations, are not currently required to keep records of occupational injuries and illnesses under Article 2 (commencing with Section 14301) of Subchapter 1 of Chapter 7 of Division 1 of Title 8 of the California Code of Regulations~~. These industries, identified by their Standard Industrial Classification Codes, as published by the United States Office of Management and Budget in the Manual of Standard Industrial Classification Codes, 1987 Edition, are apparel and accessory stores (Code 56), eating and drinking places (Code 58), miscellaneous retail (Code 59), finance, insurance, and real estate (Codes 60–67), personal services (Code 72), business services (Code 73), motion pictures (Code 78) except motion picture production and allied services (Code 781), legal services (Code 81), educational services (Code 82), social services (Code 83), museums, art galleries, and botanical and zoological gardens (Code 84), membership organizations (Code 86), engineering, accounting, research, management, and related services (Code 87), private households (Code 88), and miscellaneous services (Code 89). To further identify industries that may be included on the list, the division shall also consider data from a rating organization, as defined in Section 11750.1 of the Insurance Code, the Division of Labor Statistics and Research, ~~including the logs of occupational injuries and illnesses maintained by employers on Form CAL/OSHA No. 200, or its equivalent, as required by Section 14301 of Title 8 of the California Code of Regulations,~~ and all other appropriate information. The list shall be established by June 30, 1994, and shall be reviewed, and as necessary revised, biennially.

(3) The division shall prepare a Model Injury and Illness Prevention Program for Employers in Industries with Intermittent Employment, and shall determine which industries have historically utilized seasonal or intermittent employees. An employer in an industry determined by the division to have historically utilized seasonal or intermittent employees shall be deemed to have complied with the requirements of subdivision (a) with respect to a written injury prevention program if the employer adopts the model program prepared by the division pursuant to this paragraph and complies with any instructions relating thereto.

(k) With respect to any county, city, city and county, or district, or any public or quasi-public corporation or public agency therein, including any public entity, other than a state agency, that is a member of, or created by, a joint powers agreement, subdivision (d) shall not apply.

(*l*) Every workers' compensation insurer shall conduct a review, including a written report as specified below, of the injury and illness prevention program (IIPP) of each of its insureds *with an experience modification of 2.0 or greater* within ~~four~~ *six* months of the commencement of the initial insurance policy term. The review shall determine whether the insured has implemented all of the required components of the IIPP, and evaluate their effectiveness. The training component of the IIPP shall be evaluated to determine whether training is provided to line employees, supervisors, and upper level management, and effectively imparts the information and skills each of these groups needs to ensure that all of the insured's specific health and safety issues are fully addressed by the insured. The reviewer shall prepare a detailed written report specifying the findings of the review and all recommended changes deemed necessary to make the IIPP effective. The reviewer shall be ~~an independent~~ *or work under the direction of a* licensed California professional engineer, certified safety professional, or a certified industrial hygienist.

SEC. 46. The repeal of the personal physician's or chiropractor's presumption of correctness contained in Section 4062.9 of the Labor Code made by this act shall apply to all cases, regardless of the date of injury, but shall not constitute good cause to reopen or rescind, alter, or amend any existing order, decision, or award of the Workers' Compensation Appeals Board.

SEC. 47. The amendment, addition, or repeal of, any provision of law made by this act shall apply prospectively from the date of enactment of this act, regardless of the date of injury, unless otherwise specified, but shall not constitute good cause to reopen or rescind, alter, or amend any existing order, decision, or award of the Workers' Compensation Appeals Board.

SEC. 48. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 49. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to provide relief to the state from the effects of the current workers' compensation crisis at the earliest possible time, it is necessary for this act to take effect immediately.

~~workers' compensation system by promoting the efficient delivery of high quality appropriate medical care.~~

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