

**Senate Bill No. 375**

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Passed the Senate August 26, 2013

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*Secretary of the Senate*

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Passed the Assembly August 15, 2013

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*Chief Clerk of the Assembly*

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This bill was received by the Governor this \_\_\_\_\_ day  
of \_\_\_\_\_, 2013, at \_\_\_\_\_ o'clock \_\_\_\_M.

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*Private Secretary of the Governor*

## CHAPTER \_\_\_\_\_

An act to amend Section 11435.35 of the Government Code, and to amend Sections 139.2, 139.5, 4061, 4610.5, 4903.4, and 4903.6 of the Labor Code, relating to workers' compensation.

## LEGISLATIVE COUNSEL'S DIGEST

SB 375, Committee on Labor and Industrial Relations. Workers' compensation.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing workers' compensation law establishes requirements that govern, among other things, the certification of medical examination interpreters, dispute resolution processes for medical and billing disputes, and the allowance of liens against any sum to be paid as compensation.

This bill would correct erroneous cross-references and make technical, clarifying, and conforming changes with respect to these provisions.

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

SECTION 1. Section 11435.35 of the Government Code is amended to read:

11435.35. (a) The State Personnel Board shall establish, maintain, administer, and publish annually, an updated list of certified medical examination interpreters it has determined meet the minimum standards in interpreting skills and linguistic abilities in languages designated pursuant to Section 11435.40.

(b) Court interpreters certified pursuant to Section 68562 and administrative hearing interpreters certified pursuant to Section 11435.30 shall be deemed certified for purposes of this section.

(c) (1) In addition to the certification procedure provided pursuant to subdivision (a), the Administrative Director of the Division of Workers' Compensation may establish, maintain, administer, and publish annually an updated list of certified medical examination interpreters who, based on testing by an independent

organization designated by the administrative director, have been determined to meet the minimum standards in interpreting skills and linguistic abilities in languages designated pursuant to Section 11435.40, for purposes of medical examinations conducted pursuant to proceedings of the Workers' Compensation Appeals Board, and medical examinations conducted pursuant to Division 4 (commencing with Section 3200) of the Labor Code. The independent testing organization shall have no financial interest in the training of interpreters or in the employment of interpreters for medical examinations.

(2) (A) A fee, as determined by the administrative director, shall be collected from each interpreter seeking certification. The fee shall not exceed the reasonable regulatory costs of administering the testing and certification program and of publishing the list of certified medical examination interpreters on the Division of Workers' Compensation's Internet Web site.

(B) The Legislature finds and declares that the services described in this section are of such a special and unique nature that they may be contracted out pursuant to paragraph (3) of subdivision (b) of Section 19130. The Legislature further finds and declares that the services described in this section are a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130.

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 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 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. Preference in assigning panels shall be given to cases in which the employee is not represented. If a panel is not assigned within 20 working days, the employee shall have the right to obtain a medical evaluation from any qualified medical evaluator of his or her choice within a reasonable geographic area. 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 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. An evaluator shall not conduct qualified medical evaluations at more than 10 locations.

(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:

(i) When the evaluator has not received test results or consulting physician's evaluations in time to meet the 30-day 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.

(B) For purposes of subparagraph (A), “good cause” means any of the following:

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

(ii) Death in the evaluator’s family.

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

(C) The administrative director shall develop timeframes governing availability of qualified medical evaluators for unrepresented employees under Section 4062.1. 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 Sections 4660 and 4660.1.

(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 139.5 of the Labor Code is amended to read:

139.5. (a) (1) The administrative director shall contract with one or more independent medical review organizations and one or more independent bill review organizations to conduct reviews pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4. The independent review organizations shall be independent of any workers' compensation insurer or workers' compensation claims administrator doing business in this state. The administrative director may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4, that an organization shall be required to meet in order to qualify as an independent review organization and to assist the division in carrying out its responsibilities.

(2) To enable the independent review program to go into effect for injuries occurring on or after January 1, 2013, and until the administrative director establishes contracts as otherwise specified by this section, independent review organizations under contract with the Department of Managed Health Care pursuant to Section 1374.32 of the Health and Safety Code may be designated by the administrative director to conduct reviews pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4. The administrative director may use an interagency agreement to implement the independent review process beginning January 1, 2013. The administrative director may initially contract directly with the same organizations that are under contract with the Department of Managed Health Care on substantially the same terms without competitive bidding until January 1, 2015.

(b) (1) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be consultants for purposes of this section.

(2) There shall be no monetary liability on the part of, and no cause of action shall arise against, any consultant on account of any communication by that consultant to the administrative director or any other officer, employee, agent, contractor, or consultant of the Division of Workers' Compensation, or on account of any communication by that consultant to any person when that

communication is required by the terms of a contract with the administrative director pursuant to this section and the consultant does all of the following:

(A) Acts without malice.

(B) Makes a reasonable effort to determine the facts of the matter communicated.

(C) Acts with a reasonable belief that the communication is warranted by the facts actually known to the consultant after a reasonable effort to determine the facts.

(3) The immunities afforded by this section shall not affect the availability of any other privilege or immunity which may be afforded by law. Nothing in this section shall be construed to alter the laws regarding the confidentiality of medical records.

(c) (1) An organization contracted to perform independent medical review or independent bill review shall be required to employ a medical director who shall be responsible for advising the contractor on clinical issues. The medical director shall be a physician and surgeon licensed by the Medical Board of California or the California Osteopathic Medical Board.

(2) The independent review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent review organization shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(A) The employer, insurer or claims administrator, or utilization review organization.

(B) Any officer, director, employee of the employer, or insurer or claims administrator.

(C) A physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute.

(D) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided.

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

(F) The employee or the employee's immediate family, or the employee's attorney.

(d) The independent review organizations shall meet all of the following requirements:

(1) The organization shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a workers' compensation insurer, claims administrator, or a trade association of workers' compensation insurers or claims administrators. A board member, director, officer, or employee of the independent review organization shall not serve as a board member, director, or employee of a workers' compensation insurer or claims administrator. A board member, director, or officer of a workers' compensation insurer or claims administrator or a trade association of workers' compensation insurers or claims administrators shall not serve as a board member, director, officer, or employee of an independent review organization.

(2) The organization shall submit to the division the following information upon initial application to contract under this section and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars (\$100,000), if any.

(C) The names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any employer, workers' compensation insurer, claims administrator, medical provider network, managed care organization, provider group, or board or committee of an employer, workers' compensation insurer, claims administrator, medical provider network, managed care organization, or provider group.

(E) (i) The percentage of revenue the independent review organization receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, utilization reviews, and bill reviews.

(ii) The names of any workers' compensation insurer, claims administrator, or provider group for which the independent review organization provides review services, including, but not limited to, utilization review, bill review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process, including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise that the medical professionals are credentialed to review.

(H) A description of how the independent review organization ensures compliance with the conflict-of-interest requirements of this section.

(3) The organization shall demonstrate that it has a quality assurance mechanism in place that does all of the following:

(A) Ensures that any medical professionals retained are appropriately credentialed and privileged.

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

(C) Ensures 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 and the medical necessity of treatments or therapies in question.

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

(E) Ensures the independence of the medical professionals or bill reviewers retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts of interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall

be licensed physicians, as defined by Section 3209.3, in good standing, who meet the following minimum requirements:

(A) The physician 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 physician shall hold a nonrestricted license in any state of the United States, and for physicians and surgeons holding an M.D. or D.O. degree, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. The independent medical review organization shall give preference to the use of a physician licensed in California as the reviewer.

(C) The physician 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.

(D) Commencing January 1, 2014, the physician shall not hold an appointment as a qualified medical evaluator pursuant to Section 139.2.

(5) Neither the expert reviewer, nor the independent review organization, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The employer, workers' compensation insurer or claims administrator, or a medical provider network of the insurer or claims administrator, except that an academic medical center under contract to the insurer or claims administrator to provide services to employees may qualify as an independent medical review organization provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the employer or workers' compensation insurer or claims administrator.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the employee whose condition is under review.

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

(6) For purposes of this subdivision, the following terms shall have the following meanings:

(A) “Material familial affiliation” means any relationship as a spouse, child, parent, sibling, spouse’s parent, or child’s spouse.

(B) “Material financial affiliation” means any financial interest of more than 5 percent of total annual revenue or total annual income of an independent review organization or individual to which this subdivision applies. “Material financial affiliation” does not include payment by the employer to the independent review organization for the services required by the administrative director’s contract with the independent review organization, nor does “material financial affiliation” include an expert’s participation as a contracting medical provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(C) “Material professional affiliation” means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent review organization. “Material professional affiliation” does not include affiliations that are limited to staff privileges at a health facility.

(e) The division shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the administrative director, filed with it by an independent review organization under contract pursuant to this section. The division may charge a fee to the interested person for copying the requested information.

(f) The Legislature finds and declares that the services described in this section are of such a special and unique nature that they must be contracted out pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code. The Legislature further finds and declares that the services described in this section are a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code.

SEC. 4. Section 4061 of the Labor Code is amended to read:

4061. This section shall not apply to the employee’s dispute of a utilization review decision under Section 4610, nor to the employee’s dispute of the medical provider network treating

physician's diagnosis or treatment recommendations under Sections 4616.3 and 4616.4.

(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. 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, whether there is need for future medical care, and whether an indemnity payment will be deferred pursuant to paragraph (2) of subdivision (b) of Section 4650.

(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 whether there will be the need for future 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.

(b) If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and the employee is represented by an attorney, a medical evaluation to determine permanent disability shall be obtained as provided in Section 4062.2.

(c) If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and 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. Either party may request a comprehensive medical evaluation to determine permanent disability or the need for future medical care, and the evaluation shall be obtained only by the procedure provided in Section 4062.1.

(d) (1) Within 30 days of receipt of a report from a qualified medical evaluator who has evaluated an unrepresented employee, the unrepresented employee or the employer may each request one supplemental report seeking correction of factual errors in the report. Any of these requests shall be made in writing. A request made by the employer shall be provided to the employee, and a request made by the employee shall be provided to the employer, insurance carrier, or claims administrator at the time the request is sent to the evaluator. A request for correction that is made by the employer shall also inform the employee of the availability of information and assistance officers to assist him or her in responding to the request, if necessary.

(2) The permanent disability rating procedure set forth in subdivision (e) shall not be invoked by the unrepresented employee or the employer when a request for correction pursuant to paragraph (1) is pending.

(e) 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 or 4660.1, as applicable, and serve the rating on the employee and employer.

(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 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.

(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 or 4660.1, as applicable, and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer.

(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, except as provided pursuant to paragraph (2) of subdivision (b) of Section 4650, or promptly commence proceedings before the appeals board to resolve the dispute.

(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.

(i) No issue relating to a dispute over the existence or extent of permanent impairment and limitations 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 and by either 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 resulting from the injury shall be obtained, 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.

SEC. 5. Section 4610.5 of the Labor Code is amended to read: 4610.5. (a) This section applies to the following disputes:

(1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.

(2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(b) A dispute described in subdivision (a) shall be resolved only in accordance with this section.

(c) For purposes of this section and Section 4610.6, the following definitions apply:

(1) “Disputed medical treatment” means medical treatment that has been modified, delayed, or denied by a utilization review decision.

(2) “Medically necessary” and “medical necessity” mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee’s medical condition:

(A) The guidelines adopted by the administrative director pursuant to Section 5307.27.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(3) “Utilization review decision” means a decision pursuant to Section 4610 to modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402.

(4) Unless otherwise indicated by context, “employer” means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

(d) If a utilization review decision denies, modifies, or delays a treatment recommendation, the employee may request an independent medical review as provided by this section.

(e) A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review in accordance with this section.

(f) As part of its notification to the employee regarding an initial utilization review decision that denies, modifies, or delays a treatment recommendation, the employer shall provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative director’s designee to initiate an independent medical review. The employer shall include on the form any information required by the administrative director to facilitate the completion of the independent medical review. The form shall also include all of the following:

(1) Notice that the utilization review decision is final unless the employee requests independent medical review.

(2) A statement indicating the employee's consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter, to be signed by the employee.

(3) Notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding the following:

(A) The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.

(B) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.

(C) Reasonable information supporting the employee's position that the disputed medical treatment is or was medically necessary for the employee's medical condition, including all information provided to the employee by the employer or by the treating physician, still in the employee's possession, concerning the employer's or the physician's decision regarding the disputed medical treatment, as well as any additional material that the employee believes is relevant.

(g) The independent medical review process may be terminated at any time upon the employer's written authorization of the disputed medical treatment.

(h) (1) The employee may submit a request for independent medical review to the division no later than 30 days after the service of the utilization review decision to the employee.

(2) If at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(3) If the employer fails to comply with subdivision (f) at the time of notification of its utilization review decision, the time limitations for the employee to submit a request for independent medical review shall not begin to run until the employer provides the required notice to the employee.

(4) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf. A request submitted by a provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.

(i) An employer shall not engage in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the employer to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day that proper notification to the employee is delayed. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(j) For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee.

(k) The administrative director or his or her designee shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the employer agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.

(l) Upon notice from the administrative director that an independent review organization has been assigned, the employer shall provide to the independent medical review organization all of the following documents within 10 days of notice of assignment:

(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following:

- (A) The employee's current medical condition.
- (B) The medical treatment being provided by the employer.
- (C) The disputed medical treatment requested by the employee.

(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.

(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for the disputed treatment.

(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to deny, modify, or delay the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.

(m) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a copy of medical records required by this subdivision to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

(n) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and

documents required by subdivision (l) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

(o) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee.

SEC. 6. Section 4903.4 of the Labor Code is amended to read:

4903.4. (a) If a dispute arises concerning a lien for expenses incurred by or on behalf of the injured employee as provided by Article 2 (commencing with Section 4600) of Chapter 2 of Part 2, the appeals board may resolve the dispute in a separate proceeding, which may include binding arbitration upon agreement of the employer, lien claimant, and the employee, if the employee remains a party to the dispute, according to the rules of practice and procedure.

(b) If the dispute is heard at a separate proceeding it shall be calendared for hearing or hearings as determined by the appeals board based upon the resources available to the appeals board and other considerations as the appeals board deems appropriate and shall not be subject to Section 5501.5.

SEC. 7. Section 4903.6 of the Labor Code is amended to read:

4903.6. (a) Except as necessary to meet the requirements of Section 4903.5, a lien claim or application for adjudication shall not be filed or served under subdivision (b) of Section 4903 until both of the following have occurred:

(1) Sixty days have elapsed after the date of acceptance or rejection of liability for the claim, or expiration of the time provided for investigation of liability pursuant to subdivision (b) of Section 5402, whichever date is earlier.

(2) Either of the following:

(A) The time provided for payment of medical treatment bills pursuant to Section 4603.2 has expired and, if the employer objected to the amount of the bill, the reasonable fee has been determined pursuant to Section 4603.6, and, if authorization for the medical treatment has been disputed pursuant to Section 4610, the medical necessity of the medical treatment has been determined pursuant to Sections 4610.5 and 4610.6.

(B) The time provided for payment of medical-legal expenses pursuant to Section 4622 has expired and, if the employer objected to the amount of the bill, the reasonable fee has been determined pursuant to Section 4603.6.

(b) All lien claimants under Section 4903 shall notify the employer and the employer's representative, if any, and the employee and his or her representative, if any, and the appeals board within five working days of obtaining, changing, or discharging representation by an attorney or nonattorney representative. The notice shall set forth the legal name, address, and telephone number of the attorney or nonattorney representative.

(c) A declaration of readiness to proceed shall not be filed for a lien under subdivision (b) of Section 4903 until the underlying case has been resolved or where the applicant chooses not to proceed with his or her case.

(d) With the exception of a lien for services provided by a physician as defined in Section 3209.3, a lien claimant shall not be entitled to any medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code, about an injured worker without prior written approval of the appeals board. Any order authorizing disclosure of medical information to a lien claimant other than a physician shall specify the information to be provided to the lien claimant and include a finding that the information is relevant to the proof of the matter for which the information is sought. The appeals board shall adopt reasonable regulations to ensure compliance with this section, and shall take any further steps as may be necessary to enforce the regulations, including, but not limited to, impositions of sanctions pursuant to Section 5813.

(e) The prohibitions of this section shall not apply to lien claims, applications for adjudication, or declarations of readiness to proceed filed by or on behalf of the employee, or to the filings by or on behalf of the employer.









Approved \_\_\_\_\_, 2013

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*Governor*