SENATE BILL No. 626

Introduced by Senator Beall

February 22, 2013

An act to amend Sections 4600, 4610, 4610.6, 4616, and 4660.1 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 626, as introduced, Beall. Workers' compensation.

Existing law establishes a worker's 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 law generally provides for the reimbursement of medical providers for services rendered in connection with the treatment of a worker's injury. Existing law authorizes, with some exceptions, the employee to be treated by a physician of his or her own choice or at a facility of his or her own choice after 30 days from the date the injury is reported. Existing law prohibits a chiropractor from being the treating physician after the employee has received the maximum number of chiropractic visits.

This bill would delete that provision and would instead provide that a physician, as defined, may remain the patient's primary treating physician even if additional treatment has been denied as long as the physician complies with specified reporting requirements.

Existing law requires an employer to establish a medical treatment utilization review process and, in this regard, prohibits any person other than a licensed physician from modifying, delaying, or denying requests for authorization of medical treatment for reasons of medical necessity to cure and relieve. Existing law also provides for an independent medical review process to resolve disputes over a utilization review decision for injuries occurring on or after January 1, 2013, and for any

decision that is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

This bill would revise these provisions to require that medical treatment utilization reviews and independent medical reviews be conducted by physicians or medical professionals, as applicable, who hold the same California license as the requesting physician. The bill would delete the requirement that independent medical review organization keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization.

Existing law prohibits a workers' compensation administrative law judge, the appeals board, or any higher court from making a determination of medical necessity contrary to the determination of the independent medical review organization.

This bill would delete that provision.

Existing law provides certain methods for determining workers' compensation benefits payable to a worker or his or her dependents for purposes of permanent partial disability and permanent total disability for injuries occurring on or after January 1, 2013. Existing law requires that the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of injury be taken into account in determining the percentages of permanent partial disability or permanent total disability. Existing law, with some exceptions, prohibits increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, as specified.

This bill would delete the prohibition on increases in impairment ratings for psychiatric disorder and would make related changes.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. 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 apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury

shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(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.

(c) Unless the employer or the employer's insurer has established or contracted with 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. ~~A chiropractor shall not be a treating physician after the employee has received the maximum number of chiropractic visits allowed by subdivision (d) of Section 4604.5.~~ *A physician, as defined in Section 3209.3, may remain the employee's primary treating physician even if additional medical treatment, as specified in the medical treatment utilization schedule adopted under Section 5307.27, has been denied, as long as the physician complies with the reporting requirements set forth by the administrative director.*

(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 the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a plan, policy, or fund as described in subdivisions (b), (c), and (d) of Section 4616.7.

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

(A) Be 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) Be 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. "Personal physician" includes a medical group, if the medical group is a single corporation or partnership

composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries.

(C) The physician agrees to be predesignated.

(3) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury 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, 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 employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a group health insurance policy 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) An employee shall be entitled to all medically appropriate referrals by the personal physician to other physicians or medical providers within the nonoccupational health care plan. An employee shall be entitled to treatment by physicians or other medical providers outside of the nonoccupational health care plan pursuant to standards established in Article 5 (commencing with Section 1367) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(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.

(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 Human Resources 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.

(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.

(g) If the injured employee cannot effectively communicate with his or her treating physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments. To be a qualified interpreter for purposes of medical treatment appointments, an interpreter is not required to meet the requirements of subdivision (f), but shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code. The administrative director shall adopt a fee schedule for qualified interpreter fees in accordance with this section. Upon request of the injured employee, the employer or insurance carrier shall pay for interpreter services. An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless

either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.

(h) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and subject to Section 5307.1 or 5703.8. The employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription.

SEC. 2. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information

reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a ~~licensed~~ physician *who holds the same California license as that held by the requesting physician* who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements shall be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(2) When the employee's condition is such that the employee faces 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, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director.

If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the

information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(6) A utilization review decision to modify, delay, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

SEC. 3. Section 4610.6 of the Labor Code is amended to read:

4610.6. (a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information and documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in subdivision (c) of Section 4610.5.

(d) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director. If the disputed medical treatment has not been provided and the employee's provider or

the administrative director certifies in writing that an imminent and serious threat to the health of the 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 health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. ~~The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization.~~ *Independent medical reviews shall be conducted by medical professionals who hold the same California license as the requesting physician.* If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the

medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of the administrative director's powers.

(2) The determination of the administrative director was procured by fraud.

(3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

(i) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization. In the event that a different independent medical review organization is not available after remand, the administrative director shall submit the dispute to the original medical review organization for review by a different reviewer in the organization. ~~In no event shall a workers' compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization.~~

(j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement

for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision (*l*) 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 the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(*l*) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews and the cost of administering the independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors.

(m) The administrative director may publish the results of independent medical review determinations after removing individually identifiable information.

(n) If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby.

SEC. 4. Section 4616 of the Labor Code is amended to read:

4616. (a) (1) On or after January 1, 2005, an insurer, employer, or entity that provides physician network services 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. 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 and areas in which there is a health care shortage.

(3) Commencing January 1, 2014, a treating physician shall be included in the network only if, at the time of entering into or renewing an agreement by which the physician would be in the network, the physician, or an authorized employee of the physician or the physician's office, provides a separate written acknowledgment in which the physician affirmatively elects to be a member of the network. Copies of the written acknowledgment shall be provided to the administrative director upon the administrative director's request. This paragraph shall not apply to a physician who is a shareholder, partner, or employee of a medical group that elects to be part of the network.

(4) Commencing January 1, 2014, every medical provider network shall post on its Internet Web site a roster of all treating physicians in the medical provider network and shall update the roster at least quarterly. Every network shall provide to the administrative director the Internet Web site address of the network and of its roster of treating physicians. The administrative director shall post, on the division's Internet Web site, the Internet Web site address of every approved medical provider network.

(5) Commencing January 1, 2014, every medical provider network shall provide one or more persons within the United States to serve as medical access assistants to help an injured employee find an available physician of the employee's choice, and subsequent physicians if necessary, under Section 4616.3. Medical access assistants shall have a toll-free telephone number that injured employees may use and shall be available at least from 7 a.m. to 8 p.m. Pacific Standard Time, Monday through Saturday, inclusive, to respond to injured employees, contact physicians' offices during regular business hours, and schedule appointments. The administrative director shall promulgate regulations on or before July 1, 2013, governing the provision of medical access assistants.

(b) (1) An insurer, employer, or entity that provides physician network services shall submit a plan for the medical provider network to the administrative director for approval. The administrative director shall approve the plan for a period of four years 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. Commencing January 1, 2014, existing approved plans shall be deemed approved for a period of four years from the most recent application or modification approval date. Plans for reapproval for medical provider networks shall be submitted at least six months before the expiration of the four-year approval period. Upon a showing that the medical provider network was approved or deemed approved by the administrative director, there shall be a conclusive presumption on the part of the appeals board that the medical provider network was validly formed.

(2) Every medical provider network shall establish and follow procedures to continuously review the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

(3) Every medical provider network shall submit geocoding of its network for reapproval to establish that the number and geographic location of physicians in the network meets the required access standards.

(4) The administrative director shall at any time have the discretion to investigate complaints and to conduct random reviews of approved medical provider networks.

(5) Approval of a plan may be denied, revoked, or suspended if the medical provider network fails to meet the requirements of this article. Any person contending that a medical provider network is not validly constituted may petition the administrative director to suspend or revoke the approval of the medical provider network. The administrative director may adopt regulations establishing a schedule of administrative penalties not to exceed five thousand dollars ($5,000) per violation, or probation, or both, in lieu of revocation or suspension for less severe violations of the requirements of this article. Penalties, probation, suspension, or revocation shall be ordered by the administrative director only after notice and opportunity to be heard. Unless suspended or revoked by the administrative director, the administrative director's approval of a medical provider network shall be binding on all persons and all courts. A determination of the administrative director may be reviewed only by an appeal of the determination of the administrative director filed as an original proceeding before the reconsideration unit of the workers' compensation appeals board on the same grounds and within the same time limits after issuance of the determination as would be applicable to a petition for reconsideration of a decision of a workers' compensation administrative law judge.

(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.

(f) No person other than a ~~licensed~~ physician *who holds the same California license as the requesting 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) Commencing January 1, 2013, every contracting agent that sells, leases, assigns, transfers, or conveys its medical provider networks and their contracted reimbursement rates to an insurer, employer, entity that provides physician network services, or another contracting agent shall, upon entering or renewing a provider contract, disclose to the provider whether the medical provider network may be sold, leased, transferred, or conveyed to other insurers, employers, entities that provide physician network services, or another contracting agent, and specify whether those insurers, employers, entities that provide physician network services, or contracting agents include workers' compensation insurers.

(h) 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.

SEC. 5. Section 4660.1 of the Labor Code is amended to read:

4660.1. This section shall apply to injuries occurring on or after January 1, 2013.

(a) In determining the percentages of permanent partial or permanent total 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 injury.

(b) 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) with the employee's whole person impairment, as provided in the Guides, multiplied by an adjustment factor of 1.4.

(c) ~~(1) Except as provided in paragraph (2), there~~ *There* shall be no increases in impairment ratings for sleep dysfunction~~,~~ *or* sexual dysfunction,~~ or psychiatric disorder, or any combination thereof~~ *or both*, arising out of a compensable physical injury. Nothing in this section shall limit the ability of an injured employee to obtain treatment for sleep dysfunction~~,~~ *or* sexual dysfunction~~, or psychiatric disorder~~, if any, that are a consequence of an industrial injury.

~~(2) An increased impairment rating for psychiatric disorder shall not be subject to paragraph (1) if the compensable psychiatric injury resulted from either of the following:~~

~~(A) Being a victim of a violent act or direct exposure to a significant violent act within the meaning of Section 3208.3.~~

~~(B) A catastrophic injury, including, but not limited to, loss of a limb, paralysis, severe burn, or severe head injury.~~

(d) The administrative director may formulate a schedule of age and occupational modifiers and may amend the schedule for the determination of the age and occupational modifiers in accordance with this section. The Schedule for Rating Permanent Disabilities pursuant to the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) and the schedule of age and occupational modifiers 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. Until the schedule of age and occupational modifiers is amended, for injuries occurring on or after January 1, 2013, permanent disabilities shall be rated using the age and occupational modifiers in the permanent disability rating schedule adopted as of January 1, 2005.

(e) The schedule of age and occupational modifiers shall promote consistency, uniformity, and objectivity.

(f) The schedule of age and occupational modifiers and any amendment thereto or revision thereof shall apply prospectively and shall apply to and govern only those permanent disabilities that result from compensable injuries received or occurring on and after the effective date of the adoption of the schedule, amendment, or revision, as the case may be.

(g) Nothing in this section shall preclude a finding of permanent total disability in accordance with Section 4662.

(h) In enacting the act adding this section, it is not the intent of the Legislature to overrule the holding in Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman) (2010) 187 Cal.App.4th 808.

(i) The Commission on Health and Safety and Workers' Compensation shall conduct a study to compare average loss of earnings for employees who sustained work-related injuries with permanent disability ratings under the schedule, and shall report

the results of the study to the appropriate policy and fiscal committees of the Legislature no later than January 1, 2016.

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