

Assembly Bill No. 204

CHAPTER 440

An act to amend Sections 3209.5, 4600, 4600.3, 4600.5, and 4601 of the Labor Code, relating to workers' compensation.

[Approved by Governor September 13, 1998. Filed with Secretary of State September 14, 1998.]

LEGISLATIVE COUNSEL'S DIGEST

AB 204, Migden. Workers' compensation: acupuncturists.

Existing workers' compensation law requires employers to offer necessary medical treatment and services to injured employees.

This bill would add acupuncture to the list of available treatments and make conforming changes.

Existing law allows employees to choose a personal physician or personal chiropractor for treatment.

This bill would also allow employees to choose a personal acupuncturist for treatment.

Existing law requires health care service plans to provide injured employees with chiropractic services for work-related injuries, if they so choose.

This bill would also require health care service plans to provide injured employees with acupuncture services for work-related injuries, if they so choose.

Existing law requires an employer, upon the request of an employee, to tender the employee one change of physician or chiropractor within 5 working days.

This bill would permit an employee to alternatively request an acupuncturist as a part of the one change.

This bill would incorporate additional amendments to Section 4600 of the Labor Code proposed by AB 236, contingent on the prior enactment of that bill.

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

SECTION 1. Section 3209.5 of the Labor Code is amended to read:

3209.5. Medical, surgical, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, includes but is not limited to services and supplies by physical therapists, chiropractic practitioners, and acupuncturists, as licensed by California state law and within the scope of their practice as defined by law.

SEC. 2. Section 4600 of the Labor Code is amended to read:

4600. Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve from the effects of the injury shall be provided by the employer. In the case of his or her neglect or refusal seasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment. After 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. However, if an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury. If an employee requests a change of physician pursuant to Section 4601, the request may be made at any time after the injury, and the alternative physician, chiropractor, or acupuncturist shall be provided within five days of the request as required by Section 4601. For the purpose of this section, "personal physician" means the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history.

Where at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation judge, the employee submits to examination by a physician, he or she shall be entitled to receive in addition to all other benefits herein provided all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination. Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents (\$0.21) a mile or the mileage rate adopted by the Director of the Department of Personnel Administration pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination.

Where at the request of the employer, the employer's insurer, the administrative director, the appeals board, a workers' compensation judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be



provided by the employer. For purposes of this section, “qualified interpreter” means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

SEC. 2.5. Section 4600 of the Labor Code is amended to read:

4600. Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve from the effects of the 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. After 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. However, if an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury. If an employee requests a change of physician pursuant to Section 4601, the request may be made at any time after the injury, and the alternative physician, chiropractor, or acupuncturist shall be provided within five days of the request as required by Section 4601. For the purpose of this section, “personal physician” means the employee’s regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has previously directed the medical treatment of the employee, and who retains the employee’s medical records, including his or her medical history.

Where at the request of the employer, the employer’s insurer, the administrative director, the appeals board, or a workers’ compensation judge, the employee submits to examination by a physician, he or she shall be entitled to receive in addition to all other benefits herein provided all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination. Regardless of the date of injury, “reasonable expenses of transportation” includes mileage fees from the employee’s home to the place of the examination and back at the rate of twenty-one cents (\$0.21) a mile or the mileage rate adopted by the Director of the Department of Personnel Administration pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination.



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

SEC. 3. Section 4600.3 of the Labor Code is amended to read:

4600.3. (a) (1) Notwithstanding Section 4600, when a self-insured employer, group of self-insured employers, or the insurer of an employer contracts with at least two health care organizations certified pursuant to Section 4600.5 for health care services required by this article to be provided to injured employees, those employees who are subject to the contract shall receive medical services in the manner prescribed in the contract, providing that the employee may choose to be treated by a personal physician, personal chiropractor, or personal acupuncturist that he or she has designated prior to the injury, in which case the employee shall not be treated by the health care organization. Every employee shall be given an affirmative choice at the time of employment and at least annually thereafter to designate or change the designation of a health care organization or a personal physician, personal chiropractor, or personal acupuncturist. The choice shall be memorialized in writing and maintained in the employee's personnel records. The employee who has designated a personal physician, personal chiropractor, or personal acupuncturist may change their designated caregiver at any time prior to the injury. Any employee who fails to choose between health care organizations or to designate a personal physician, personal chiropractor, or personal acupuncturist shall be treated by the health care organization selected by the employer.

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



(3) The employee shall be allowed to choose from at least two health care organizations, of which at least one must be compensated on a fee-for-service basis. If one or more of the health care organizations offered by the employer is the workers' compensation insurer that covers the employee or is an entity that controls or is controlled by that insurer, as defined by Section 1215 of the Insurance Code, the employee shall be allowed to choose from at least one additional health care organization, that is not the workers' compensation insurer that covers the employee, or entities that control or are controlled by that insurer, of which at least one must be compensated on a fee-for-service basis.

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

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

(c) (1) When an employee is not receiving or is not eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, if 90 days from the date the injury is reported the employee who has been receiving treatment from a health care organization or his or her physician, chiropractor, acupuncturist, or other agent notifies his or her employer in writing that he or she desires to stop treatment by the health care organization, he or she shall have the right to be treated by a physician, chiropractor, or acupuncturist or at a facility of his or her own choosing within a reasonable geographic area.

(2) When an employee is receiving or is eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, and has agreed to receive care for occupational



injuries and illnesses from a health care organization provided by the employer, the employee may be treated for occupational injuries and diseases by a physician, chiropractor, or acupuncturist of his or her own choice or at a facility of his or her own choice within a reasonable geographic area if the employee or his or her physician, chiropractor, acupuncturist, or other agent notifies his or her employer in writing only after 180 days from the date the injury was reported, or upon the date of contract renewal or open enrollment of the health care organization, whichever occurs first, but in no case until 90 days from the date the injury was reported.

(3) If the employee is receiving or is eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, and his or her physician, chiropractor, or acupuncturist for nonoccupational illnesses or injuries is participating in at least one of the health care organizations offered to the employee, and he or she has chosen treatment by one of these health care organizations for occupational injuries or illnesses, the employee may be treated by a physician, chiropractor, or acupuncturist of his or her own choice or at a facility of his or her own choice within a reasonable geographic area if the employee or his or her physician, chiropractor, acupuncturist, or other agent notifies his or her employer in writing only after 365 days from the date the injury was reported, or upon the date of contract renewal or open enrollment, whichever occurs first, but in no case until 90 days from the date the injury was reported.

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

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

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

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

(g) Notwithstanding subdivision (c), in the event that the employer, group of employers, or the employer's workers' compensation insurer no longer contracts with the health care organization that has been treating an injured employee, the employee may continue treatment provided or arranged by the



health care organization. If the employee does not choose to continue treatment by the health care organization, the employer may control the employee's treatment for 30 days from the date the injury was reported. After that period, 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.

SEC. 4. Section 4600.5 of the Labor Code is amended to read:

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

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

(c) If the health care organization is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, the administrative director shall certify the plan to provide health care pursuant to Section 4600.3 if the director finds that the plan is in good standing with the Department of Corporations and meets the following additional requirements:

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

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

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Corporations in compliance with the Knox-Keene Health Care Service Plan Act, relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical



treatment to injured employees in compliance with the requirements of this code.

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

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

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

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

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

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

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

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

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

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



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

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

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

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

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

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

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

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

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

(7) Complies with the following requirements:

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



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

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

(f) (1) A workers' compensation health care provider organization authorized by the Department of Corporations on December 31, 1997, shall be eligible for certification as a health care organization under subdivision (e).

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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



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

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

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

Acupuncture utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for acupuncture care. Acupuncturists affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of acupuncture care for work-related injuries, the review shall include review by an acupuncturist affiliated with the health care organization, as determined by the health care organization.

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

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

SEC. 5. Section 4601 of the Labor Code is amended to read:

4601. (a) If the employee so requests, the employer shall tender the employee one change of physician. The employee at any time may request that the employer tender this one-time change of



physician. Upon request of the employee for a change of physician, the maximum amount of time permitted by law for the employer or insurance carrier to provide the employee an alternative physician or, if requested by the employee, a chiropractor, or an acupuncturist shall be five working days from the date of the request. Notwithstanding the 30-day time period specified in Section 4600, a request for a change of physician pursuant to this section may be made at any time. The employee is entitled, in any serious case, upon request, to the services of a consulting physician, chiropractor, or acupuncturist of his or her choice at the expense of the employer. The treatment shall be at the expense of the employer.

(b) If an employee requesting a change of physician pursuant to subdivision (a) has notified his or her employer in writing prior to the date of injury that he or she has a personal chiropractor, the alternative physician tendered by the employer to the employee, if the employee so requests, shall be the employee's personal chiropractor. For the purpose of this article, "personal chiropractor" means the employee's regular chiropractor licensed pursuant to Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code, who has previously directed treatment of the employee, and who retains the employee's chiropractic treatment records, including his or her chiropractic history.

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

SEC. 6. Section 2.5 of this bill incorporates amendments to Section 4600 of the Labor Code proposed by both this bill and AB 236. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 1999, (2) each bill amends Section 4600 of the Labor Code, and (3) this bill is enacted after AB 236, in which case Section 2 of this bill shall not become operative.

