AMENDED IN ASSEMBLY AUGUST 30, 2012

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AMENDED IN SENATE MARCH 22, 2011

SENATE BILL No. 863

Introduced by Senator De León
(Principal coauthor: Assembly Member Solorio)

February 18, 2011

An act to amend Sections 11435.30 and 11435.35 of the Government Code, and to amend Sections 62.5, 139.2, 3201.5, 3201.7, 3700.1, 3701, 3701.3, 3701.5, 3701.7, 3701.8, 3702, 3702.2, 3702.5, 3702.8, 3702.10, 3742, 3744, 3745, 3746, 4061, 4062, 4062.2, 4062.3, 4063, 4064, 4453, 4600, 4603.2, 4603.4, 4604, 4604.5, 4605, 4610, 4610.1, 4616, 4616.1, 4616.2, 4616.3, 4616.7, 4620, 4622, 4650, 4658, 4658.5, 4658.6, 4660, 4701, 4903, 4903.1, 4903.4, 4903.5, 4903.6, 4904, 4905, 4907, 5307.1, 5307.7, 5402, 5502, 5703, 5710, and 5811 of, to add Sections 139.32, *139.48,*139.5, 3701.9, 4603.3, 4603.6, 4610.5, 4610.6, 4658.7, 4660.1, 4903.05, 4903.06, 4903.07, 4903.8, 5307.8, and 5307.9 to, to add and repeal Section 3702.4 of, and to repeal Sections 4066 and 5318 of, the Labor Code, relating to workers' compensation, *and making an appropriation therefor*.

LEGISLATIVE COUNSEL'S DIGEST

SB 863, as amended, De León. 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.

(1) Existing law establishes certain requirements relating to qualified medical evaluators who perform the evaluation of medical-legal issues.

This bill would modify the requirements of a qualified medical evaluator with respect to doctors of chiropractic, and would prohibit a qualified medical evaluator from conducting qualified medical evaluations at more than 10 locations.

(2) Existing law provides that it is unlawful for a physician to refer a person for specified medical goods or services, whether for treatment or medical-legal purposes, if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral, except as specified.

This bill would additionally prohibit, except as specified, an interested party, as defined, from referring a person for certain services relating to workers' compensation provided by another entity, if the interested party has a financial interest in the other entity, as defined. The bill would provide that a violation of these provisions is a misdemeanor, and would authorize civil penalties of up to $15,000 for each offense. By creating a new crime, this bill would impose a state-mandated local program.

(3) Existing law establishes the Workers' Compensation Administration Revolving Fund for the administration of the workers' compensation program, and other specified purposes.

This bill would establish in the Department of Industrial Relations a return-to-work program, to be funded by non-General Fund revenues of one hundred twenty million dollars $120,000,000 that the bill would annually appropriate from the Workers' Compensation Administration Revolving Fund.

~~(3)~~

(4) Existing law requires the Department of Industrial Relations and the courts of this state, except as provided, to recognize as valid and binding any labor-management agreement that meets certain requirements. Existing law applies this recognition only in relation to employers that meet specified requirements.

This bill would add the State of California to the list of authorized employers for these purposes.

~~(4)~~

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

This bill would change the amount of a prescribed security deposit required of private self-insured employers, would delete a related audit requirement, and would, commencing January 1, 2013, prohibit a certificate of consent to self-insure from being issued to specified employers.

This bill would require public self-insured employers to provide certain information to the director, and would require the Commission on Health and Safety and Workers' Compensation to conduct an examination of the public self-insured program, and to publish a preliminary and final report on its Internet Web site, as specified.

Existing law requires that the cost of administration of the public self-insured program be a General Fund item.

This bill would instead require that the cost be borne by the Workers' Compensation Administration Revolving Fund.

Existing law establishes the Self-Insurers' Security Fund for purposes related to the payment of the workers' compensation obligations of self-insurers.

This bill would revise the composition of the board of trustees of the Self-Insurers' Security Fund, would revise duties of the Self-Insurers' Security Fund, and would make related changes.

~~(5)~~

(6) Existing law establishes certain procedures that govern the determination of an employee's eligibility for permanent disability indemnity commencing with the final payment of the employee's temporary disability indemnity.

This bill would revise and recast these provisions.

~~(6)~~

(7) Existing law establishes procedures for the resolution of disputes regarding the compensability of an injury. Existing law prescribes certain requirements relating to recommendations regarding spinal surgery.

This bill would delete the provisions relating to spinal surgery.

Existing law prescribes a specified procedure that governs dispute resolution relating to injuries occurring on or after January 1, 2005,

when the employee is represented by an attorney. This procedure includes various requirements relating to the selection of agreed medical evaluators.

This bill would revise and recast these provisions.

~~(7)~~

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

This bill would revise the method for determining benefits for purposes of permanent partial disability for injuries occurring on or after January 1, 2013, and on or after January 1, 2014.

This bill would provide, prior to an award of permanent disability indemnity, that no permanent disability indemnity payment be required if the employer has offered the employee a position that pays at least 85% of the wages and compensation paid to the employee at the time of injury, or if the employee is employed in a position that pays at least 100% of the wages and compensation paid to the employee at the time of injury, *as specified*.

This bill would revise the method for determining benefits for purposes of permanent disability for injuries occurring on or after January 1, 2013.

This bill would revise the amount of the award for burial expenses.

Existing law, for injuries that cause permanent partial disability and occur on or after January 1, 2004, provides supplemental job displacement benefits in the form of a nontransferable voucher for education-related retraining or skill enhancement for an injured employee who does not return to work for the employer within 60 days of the termination of temporary disability, in accordance with a prescribed schedule based on the percentage of an injured employee's disability. Existing law provides an exception for employers who meet specified criteria.

This bill would provide that the above provisions shall apply to injuries occurring on or after January 1, 2004, and before January 1, 2013.

This bill would provide, for injuries that cause permanent partial disability and occur on or after January 1, 2013, for a supplemental job displacement benefit in the form of a voucher for up to $6,000 to cover various ~~reeducation~~ *education-related retraining* and skill enhancement expenses, as specified, which would expire 2 years after the date the

voucher is furnished to the employee or 5 years after the date of injury, whichever is later. The bill would exempt employers who make an offer of employment, as specified, from providing vouchers.

Existing law requires that, in determining the percentages of permanent disability, account be taken of the nature of the injury, the occupation of the injured employee, and his or her age at the time of the injury, and requires that specified factors be considered in determining an employee's diminished earning capacity for these purposes.

This bill would provide that the above provisions shall apply to injuries occurring before January 1, 2013. This bill would, for injuries occurring on or after January 1, 2013, revise the factors to be considered in determining impairment and disability ratings for these purposes.

~~(8)~~

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

This bill would limit the provision of home health care services as medical treatment to specified circumstances.

~~(9)~~

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

This bill would revise and recast these provisions, and would establish certain procedures to govern billing procedures and disputes.

~~(10)~~

(11) Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services.

This bill would require the administrative director to contract with one or more independent medical review organizations and one or more independent bill review organizations to conduct reviews in accordance with specified criteria. The bill would require that the independent review organizations retained to conduct reviews meet specified criteria and comply with specified requirements. The bill would require that final determinations made pursuant to the independent bill review and independent medical review processes be presumed to be correct and be set aside only as specified.

The independent medical review process established by the bill would be used 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. The bill would require an independent medical review organization to conduct the review in accordance with specified provisions, and would limit this review to an examination of the medical necessity of the disputed medical treatment. The bill would prohibit an employer from engaging in any conduct that delays the medical review process, and would authorize the administrative director to levy certain administrative penalties in connection with this prohibition, to be deposited in the Workers' Compensation Administration Revolving Fund. The bill would require that the costs of independent medical review and the administration of the independent medical review system be borne by employers through a fee system established by the administrative director.

~~(11)~~

(12) Existing law authorizes an insurer or employer to establish or modify a medical provider network for the provision of medical treatment to injured employees.

This bill, commencing January 1, 2014, would require that a treating physician be included in the network only if the physician or authorized employee of the physician gives a separate written acknowledgment that the physician is a member of the network, and would require every medical provider network to include one or more persons employed as medical access assistants to help an injured employee find an available physician and assist employees in scheduling appointments.

Existing law requires an employer or insurer to submit a plan for the medical provider network to the administrative director for approval.

This bill, commencing January 1, 2014, would require that existing approved plans be deemed approved for a period of 4 years from the most recent application or modification approval date. The bill would authorize any person contending that a medical provider network is not validly constituted to petition the administrative director to suspend or revoke the approval of the medical provider network. The bill would authorize the administrative director to adopt regulations establishing a schedule of administrative penalties, not to exceed $5,000 per violation, or probation, or both, in lieu of revocation or suspension.

~~(12)~~

(13) Existing law requires an employer to pay medical-legal expenses for which the employer is liable in accordance with specified provisions.

This bill would establish a secondary review process to govern billing disputes relating to medical-legal expenses.

~~(13)~~

(14) Existing ~~workers' compensation~~ law authorizes the ~~appeals board~~ *Workers' Compensation Appeals Board* to determine and allow specified expenses as liens against any sum to be paid as compensation.

This bill would revise procedures relating to liens, including requiring that any payment of a lien for the reasonable expenses incurred by an injured employee be made only to the person who was entitled to payment for the expenses at the time the expenses were incurred, and not to an assignee, except as specified. The bill would require that certain documentation relating to a lien filing include certain declarations made under penalty of perjury. By expanding the crime of perjury, this bill would impose a state-mandated local program. This bill would require that all liens filed on or after January 1, 2013, for certain expenses, be subject to a filing fee, and that all liens and costs that were filed as liens, filed before January 1, 2013, for certain expenses, be subject to an activation fee, except as specified. The bill would dismiss by operation of law on January 1, 2014, all liens and costs filed as liens for which the filing fee or activation fee is not paid. This bill would require that all fees collected pursuant to these provisions be deposited in the Workers' Compensation Administration Revolving Fund. This bill would provide for the reimbursement of a lien filing fee or lien activation fee under specified circumstances.

This bill would make related changes with respect to liens.

~~(14)~~

(15) Existing law requires the administrative director, after public hearings, to adopt and revise periodically an official medical fee schedule that establishes reasonable maximum fees paid for medical services, other than physician services, and other prescribed goods and services in accordance with specified requirements.

This bill would require the administrative director, after public hearings, to adopt and review periodically an official medical fee schedule based on the resource-based relative value scale for physician services *and nonphysician practitioner services*, as defined by the administrative director, in accordance with specified requirements. The bill would require, commencing January 1, 2014, and until the time the administrative director has adopted an official medical fee schedule in

accordance with the resource-based relative value scale, that the maximum reasonable fees for physician services *and nonphysician practitioner services* be in accordance with the fee-related structure and rules of the Medicare payment system for physician services, and that the fees include specified conversion factors.

This bill would require the administrative director, on or before July 1, 2013, to adopt, after public hearings, a schedule for payment of home health care services that are not otherwise covered, as specified.

This bill would require the administrative director, on or before December 31, 2013, in consultation with the Commission on Health and Safety and Workers' Compensation, to adopt, after public hearings, a schedule of reasonable maximum fees payable for copy and related services.

~~(15)~~

(16) Existing law authorizes the appeals board to receive as evidence and use as proof of any fact in dispute various reports and publications.

This bill would add reports of vocational experts, as specified.

~~(16)~~

(17) Existing law provides for the reimbursement of specified expenses for a deponent in connection with a deposition requested by the employer or insurer.

This bill would require the employer to ~~arrange, provide, and~~ pay for the services of a language interpreter if interpretation services are required because the injured employee or deponent does not proficiently speak or understand the English language.

~~(17)~~

(18) Existing law requires the State Personnel Board to establish, maintain, administer, and publish annually an updated list of certified administrative hearing interpreters and medical examination interpreters it has determined meet certain minimum standards.

This bill would also authorize the administrative director or an independent organization designated by the administrative director to establish, maintain, administer, and publish annually an updated list of certified administrative hearing interpreters who, based on testing by an independent organization designated by the administrative director, have been determined to meet certain minimum standards, for purposes of ~~administrative hearings and medical examinations conducted in connection with workers' compensation and appeals to the Worker's Compensation Appeals Board~~ *certain workers' compensation proceedings and medical examinations*. This bill would require a

reasonable fee to be collected from each interpreter seeking certification, to cover the reasonable regulatory costs of administering the program.

~~(18)~~

(19) This bill would delete certain reporting requirements, delete obsolete provisions, and make conforming and clarifying changes.

(20) This bill would incorporate additional changes in Section 4903.1 of the Labor Code proposed by SB 1105 that would become operative only if SB 1105 and this bill are both chaptered and become effective on or before January 1, 2013, and this bill is chaptered last.

(21) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

SECTION 1. The Legislature finds and declares all of the following:

(a) That ~~Article 14 of Section 4~~ *Section 4 of Article XIV* of the California Constitution ~~requires~~ *authorizes the creation of a workers' compensation system that includes adequate provision for the comfort, health and safety, and general welfare of workers and their dependents to relieve them of the consequences of any work-related injury or death, irrespective of the fault of any party and requires* the administration of the workers' compensation system to accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character, all of which matters are expressly declared to be the social public policy of this state.

(b) That the current system of determining permanent disability has become excessively litigious, time consuming, procedurally burdensome and unpredictable, and that the provisions of this act will produce the necessary uniformity, consistency, and objectivity of outcomes, in accordance with the constitutional mandate to accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character, and that in enacting subdivision (c) of Section 4660.1 of the Labor

Code, the Legislature intends to eliminate questionable claims of disability when alleged to be caused by a disabling physical injury arising out of and in the course of employment while guaranteeing medical treatment as required by Division 4 (commencing with Section 3200) of the Labor Code.

(c) That in enacting this act, 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.

(d) That the current system of resolving disputes over the medical necessity of requested treatment is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine, adversely affecting the health and safety of workers injured in the course of employment.

(e) That having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care and that the provision of the act establishing independent medical review are necessary to implement that policy.

(f) That the performance of independent medical review is a service of such a special and unique nature that it must be contracted pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code, and that independent medical review is a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code that will be more expeditious, more economical, and more scientifically sound than the existing function of medical necessity determinations performed by qualified medical evaluators appointed pursuant to Section 139.2 of the Labor Code. The existing process of appointing qualified medical evaluators to examine patients and resolve treatment disputes is costly and time-consuming, and it prolongs disputes and causes delays in medical treatment for injured workers. Additionally, the process of selection of qualified medical evaluators can bias the outcomes. Timely and medically sound determinations of disputes over appropriate medical treatment require the independent and unbiased medical expertise of specialists that are not available through the civil service system.

~~(f)~~

(g) That the establishment of independent medical review and provision for limited appeal of decisions resulting from independent medical review are a necessary exercise of the Legislature's plenary power to provide for the settlement of any disputes arising under the workers' compensation laws of this state and to control the manner of review of such decisions.

(h) That the performance of independent bill review is a service of such a special and unique nature that it must be contracted pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code, and that independent bill review is a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code. Existing law provides no method of medical billing dispute resolution short of litigation. Existing law does not provide for medical billing and payment experts to resolve billing disputes, and billing issues are frequently submitted to workers' compensation judges without the benefit of independent and unbiased findings on these issues. Medical billing and payment systems are a field of technical and specialized expertise, requiring services that are not available through the civil service system. The need for independent and unbiased findings and determinations requires that this new function be contracted pursuant to subdivision (b) of Section 19130 of the Government Code.

SEC. 2. Section 11435.30 of the Government Code is amended to read:

11435.30. (a) The State Personnel Board shall establish, maintain, administer, and publish annually an updated list of certified administrative hearing interpreters it has determined meet the minimum standards in interpreting skills and linguistic abilities in languages designated pursuant to Section 11435.40. Any interpreter so listed may be examined by each employing agency to determine the interpreter's knowledge of the employing agency's technical program terminology and procedures.

(b) Court interpreters certified pursuant to Section 68562, and interpreters listed on the State Personnel Board's recommended lists of court and administrative hearing interpreters prior to July 1, 1993, 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 administrative hearing 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 administrative hearings conducted pursuant to proceedings of the Workers' Compensation Appeals Board. The independent testing organization shall have no financial interest in the training of interpreters or in the employment of interpreters for administrative hearings.

(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 administrative hearing interpreters on the Division of Workers' Compensation' 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. 3. 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 administrative hearings.

(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. 4. Section 62.5 of the Labor Code is amended to read:

62.5. (a) (1) The Workers' Compensation Administration Revolving Fund is hereby created as a special account in the State Treasury. Money in the fund may be expended by the department, upon appropriation by the Legislature, for all of the following purposes, and may not be used or borrowed for any other purpose:

(A) For the administration of the workers' compensation program set forth in this division and Division 4 (commencing with Section 3200), other than the activities financed pursuant to paragraph (2) of subdivision (a) of Section 3702.5.

(B) For the Return-to-Work Program set forth in Section 139.48.

(C) For the enforcement of the insurance coverage program established and maintained by the Labor Commissioner pursuant to Section 90.3.

(2) The fund shall consist of surcharges made pursuant to paragraph (1) of subdivision (f).

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

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

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

(4) Any moneys from penalties collected pursuant to Section 3722 as a result of the insurance coverage program established under Section 90.3 shall be deposited in the State Treasury to the credit of the Workers' Compensation Administration Revolving Fund created under this section, to cover expenses incurred by the director under the insurance coverage program. The amount of any penalties in excess of payment of administrative expenses incurred by the director for the insurance coverage program established under Section 90.3 shall be deposited in the State Treasury to the credit of the Uninsured Employers Benefits Trust Fund for nonadministrative expenses, as prescribed in paragraph (1), and notwithstanding paragraph (1), shall only be available upon appropriation by the Legislature.

(c) (1) The Subsequent Injuries Benefits Trust Fund is hereby created as a special trust fund account in the State Treasury, of which the director is trustee, and its sources of funds are as provided in paragraph (1) of subdivision (f). Notwithstanding Section 13340 of the Government Code, the fund is continuously appropriated for the nonadministrative expenses of the workers' compensation program for workers who have suffered serious injury and who are suffering from previous and serious permanent disabilities or physical impairments, in accordance with Article 5 (commencing with Section 4751) of Chapter 2 of Part 2 of Division 4, and Section 4 of Article XIV of the California Constitution, and shall not be used for any other purpose. All moneys collected shall be retained in the trust fund until paid as benefits to workers who have suffered serious injury and who are suffering from previous and serious permanent disabilities or physical impairments. Nonadministrative expenses include audits and reports of services pursuant to subdivision (c) of Section 4755. The surcharge amount for this fund shall be stated separately.

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

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

(d) The Occupational Safety and Health Fund is hereby created as a special account in the State Treasury. Moneys in the account may be expended by the department, upon appropriation by the Legislature, for support of the Division of Occupational Safety and Health, the Occupational Safety and Health Standards Board, and the Occupational Safety and Health Appeals Board, and the activities these entities perform as set forth in this division, and Division 5 (commencing with Section 6300).

(e) The Labor Enforcement and Compliance Fund is hereby created as a special account in the State Treasury. Moneys in the fund may be expended by the department, upon appropriation by

the Legislature, for the support of the activities that the Division of Labor Standards Enforcement performs pursuant to this division and Division 2 (commencing with Section 200), Division 3 (commencing with Section 2700), and Division 4 (commencing with Section 3200). The fund shall consist of surcharges imposed pursuant to paragraph (3) of subdivision (f).

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

(2) The surcharge levied by the director for the Occupational Safety and Health Fund, pursuant to paragraph (1), shall not generate revenues in excess of fifty-two million dollars ($52,000,000) on and after the 2009–10 fiscal year, adjusted for each fiscal year as appropriate to reconcile any over/under assessments from previous fiscal years pursuant to Sections 15606 and 15609 of Title 8 of the California Code of Regulations, and may increase by not more than the state-local government deflator each year thereafter through July 1, 2013, and, as appropriate, to reconcile any over/under assessments from previous fiscal years. For the 2013–14 fiscal year, the surcharge level shall return to the level in place on June 30, 2009, adjusted for inflation based on the state-local government deflator.

(3) A separate surcharge shall be levied by the director upon all employers, as defined in Section 3300, for purposes of deposit in the Labor Enforcement and Compliance Fund. The total amount of the surcharges shall be allocated between employers in proportion to payroll respectively paid in the most recent year for which payroll information is available. The director shall adopt reasonable regulations governing the manner of collection of the surcharges. In no event shall the total amount of the surcharges paid by employers exceed the amounts reasonably necessary to carry out the purposes of this section.

(4) The surcharge levied by the director for the Labor Enforcement and Compliance Fund shall not exceed thirty-seven million dollars ($37,000,000) in the 2009–10 fiscal year, adjusted as appropriate to reconcile any over/under assessments from previous fiscal years, and shall not be adjusted each year thereafter by more than the state-local government deflator, and, as appropriate, to reconcile any over/under assessments from previous fiscal years pursuant to Sections 15606 and 15609 of Title 8 of the California Code of Regulations.

(5) The regulations adopted pursuant to paragraph (1) to (4), inclusive, shall be exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(g) On and after July 1, 2013, subdivision (e) and paragraphs (2) to (4), inclusive, of subdivision (f) are inoperative, unless a later enacted statute, that is enacted before July 1, 2013, deletes or extends that date.

SEC. 5. 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 Sections 4061 and 4062. These timeframes shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, but shall also permit the employee to waive this right for a specified period of time thereafter.

(2) Procedures to be followed by all physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury in a manner consistent with Section 4660.

(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. 6. Section 139.32 is added to the Labor Code, to read:

139.32. (a) For the purpose of this section, the following definitions apply:

(1) "Financial interest in another entity" means, subject to subdivision (h), either of the following:

(A) Any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between the interested party and the other entity to which the employee is referred for services.

(B) An agreement, debt instrument, or lease or rental agreement between the interested party and the other entity that provides compensation based upon, in whole or in part, the volume or value of the services provided as a result of referrals.

(2) "Interested party" means any of the following:

(A) An injured employee.

(B) The employer of an injured employee, and, if the employer is insured, its insurer.

(C) A claims administrator, which includes, but is not limited to, a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured employer, a third-party claims administrator for an insurer, a self-insured employer, a joint powers authority, or a legally uninsured employer or a subsidiary of a claims administrator.

(D) An attorney-at-law or law firm that is representing or advising an employee regarding a claim for compensation under Division 4 (commencing with Section 3200).

(E) A representative or agent of an interested party, including either of the following:

(i) An employee of an interested party.

(ii) Any individual acting on behalf of an interested party, including the immediate family of the interested party or of an employee of the interested party. For purposes of this clause, immediate family includes spouses, children, parents, and spouses of children.

(F) A provider of any medical services or products.

(3) "Services" means, but is not limited to, any of the following:

(A) A determination regarding an employee's eligibility for compensation under Division 4 (commencing with Section 3200), that includes both of the following:

(i) A determination of a permanent disability rating under Section 4660.

(ii) An evaluation of an employee's future earnings capacity resulting from an occupational injury or illness.

(B) Services to review the itemization of medical services set forth on a medical bill submitted under Section 4603.2.

(C) Copy and document reproduction services.

(D) Interpreter services.

(E) Medical services, including the provision of any medical products such as surgical hardware or durable medical equipment.

(F) Transportation services.

(G) Services in connection with utilization review pursuant to Section 4610.

(b) All interested parties shall disclose any financial interest in any entity providing services.

(c) Except as otherwise permitted by law, it is unlawful for an interested party other than a claims administrator or a network service provider to refer a person for services provided by another entity, or to use services provided by another entity, if the other entity will be paid for those services pursuant to Division 4 (commencing with Section 3200) and the interested party has a financial interest in the other entity.

(d) (1) It is unlawful for an interested party to enter into an arrangement or scheme, such as a cross-referral arrangement, that the interested party knows, or should know, has a purpose of ensuring referrals by the interested party to a particular entity that, if the interested party directly made referrals to that other entity, would be in violation of this section.

(2) It is unlawful for an interested party to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement to refer a person for services.

(e) A claim for payment shall not be presented by an entity to any interested party, individual, third-party payer, or other entity for any services furnished pursuant to a referral prohibited under this section.

(f) An insurer, self-insurer, or other payer shall not knowingly pay a charge or lien for any services resulting from a referral for services or use of services in violation of this section.

(g) (1) A violation of this section shall be misdemeanor. If an interested party is a corporation, any director or officer of the corporation who knowingly concurs in a violation of this section shall be guilty of a misdemeanor. The appropriate licensing authority for any person subject to this section shall review the facts and circumstances of any conviction pursuant to this section and take appropriate disciplinary action if the licensee has committed unprofessional conduct, provided that the appropriate licensing authority may act on its own discretion independent of the initiation or completion of a criminal prosecution. Violations of this section are also subject to civil penalties of up to fifteen thousand dollars ($15,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney.

(2) For an interested party, a practice of violating this section shall constitute a general business practice that discharges or administers compensation obligations in a dishonest manner, which shall be subject to a civil penalty under subdivision (e) of Section 129.5.

(3) For an interested party who is an attorney, a violation of subdivision (b) or (c) shall be referred to the Board of Governors of the State Bar of California, which shall review the facts and circumstances of any violation pursuant to subdivision (b) or (c) and take appropriate disciplinary action if the licensee has committed unprofessional conduct.

(4) Any determination regarding an employee’s eligibility for compensation shall be void if that service was provided in violation of this section.

(h) The following arrangements between an interested party and another entity do not constitute a "financial interest in another entity" for purposes of this section:

(1) A loan between an interested party and another entity, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, and is adequately secured, and the loan terms are not affected by either the interested party's referral of any employee or the volume of services provided by the entity that receives the referral.

(2) A lease of space or equipment between an interested party and another entity, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either the interested party's referral of any person or the volume of services provided by the entity that receives the referral.

(3) An interested party's ownership of the corporate investment securities of another entity, including shares, bonds, or other debt instruments that were purchased on terms that are available to the general public through a licensed securities exchange or NASDAQ.

(i) The prohibitions described in this section do not apply to any of the following:

(1) Services performed by, or determinations of compensation issues made by, employees of an interested party in the course of that employment.

(2) A referral for legal services if that referral is not prohibited by the Rules of Professional Conduct of the State Bar.

(3) A physician's referral that is exempted by Section 139.31 from the prohibitions prescribed by Section 139.3.

SEC. 6.5. Section 139.48 is added to the Labor Code, to read:

139.48. There shall be in the department a return-to-work program administered by the director, funded by one hundred twenty million dollars ($120,000,000) annually derived from non-General Funds of the Workers' Compensation Administration Revolving Fund, for the purpose of making supplemental payments to workers whose permanent disability benefits are disproportionately low in comparison to their earnings loss. Eligibility for payments and the amount of payments shall be determined by regulations adopted by the director, based on findings from studies conducted by the director in consultation with the Commission on Health and Safety and Workers'

Compensation. Determinations of the director shall be subject to review at the trial level of the appeals board upon the same grounds as prescribed for petitions for reconsideration.

SEC. 7. Section 139.5 is added to the Labor Code, 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 139.32.

(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. 8. Section 3201.5 of the Labor Code is amended to read:

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

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

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

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

(4) Joint labor management safety committees.

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

(6) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be

the exclusive source of providers of rehabilitation services under this division.

(b) (1) Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division. The portion of any agreement that violates this paragraph shall be declared null and void.

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

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

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

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

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

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

(d) Employers and labor representatives who meet the eligibility requirements of this section shall be issued a letter by the administrative director advising each employer and labor

representative that, based upon the review of all documents and materials submitted as required by the administrative director, each has met the eligibility requirements of this section.

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 9. Section 3201.7 of the Labor Code is amended to read:

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

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

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

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

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

fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

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

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

(D) Joint labor management safety committees.

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

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

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

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

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

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

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

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

(4) The State of California.

(d) Any recognized or certified exclusive bargaining representative in an industry not covered by Section 3201.5, may file a petition with the administrative director seeking permission to negotiate with an employer or group of employers to enter into a labor-management agreement pursuant to this section. The petition shall specify the bargaining unit or units to be included, the names of the employers or groups of employers, and shall be accompanied by proof of the labor union's status as the exclusive bargaining representative. The current collective bargaining agreement or agreements shall be attached to the petition. The petition shall be in the form designated by the administrative director. Upon receipt of the petition, the administrative director shall promptly verify the petitioner's status as the exclusive bargaining representative. If the petition satisfies the requirements set forth in this subdivision, the administrative director shall issue a letter advising each employer and labor representative of their eligibility to enter into negotiations, for a period not to exceed one year, for the purpose of reaching agreement on a labor-management agreement pursuant to this section. The parties may jointly request, and shall be granted, by the administrative director, an additional one-year period to negotiate an agreement.

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

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

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

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

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

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

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

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

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

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

SEC. 10. Section 3700.1 of the Labor Code is amended to read:

3700.1. As used in this article:

(a) "Director" means the Director of Industrial Relations.

(b) "Private self-insurer" means a private employer which has secured the payment of compensation pursuant to Section 3701.

(c) "Trustees" means the Board of Trustees of the Self-Insurers' Security Fund.

(d) "Member" means a private self-insurer which participates in the Self-Insurers' Security Fund.

(e) "Incurred liabilities for the payment of compensation" means the sum of an estimate of future compensation, as compensation is defined by Section 3207, plus an estimate of the amount necessary to provide for the administration of claims, including legal costs.

SEC. 11. Section 3701 of the Labor Code is amended to read:

3701. (a) Each year every private self-insuring employer shall secure incurred liabilities for the payment of compensation and the performance of the obligations of employers imposed under this chapter by renewing the prior year's security deposit or by making a new deposit of security. If a new deposit is made, it shall be posted within 60 days of the filing of the self-insured employer's annual report with the director, but in no event later than May 1.

(b) The solvency risk and security deposit amount for each private and group self-insurer shall be acceptable to the Self-Insurers' Security Fund.

(c) Unless otherwise permitted by regulation, the deposit shall be an amount equal to the self-insurer's projected losses, net of specific excess insurance coverage, if any, and inclusive of incurred but not reported (IBNR) liabilities, allocated loss adjustment expense, and unallocated loss adjustment expense, calculated as of December 31 of each year. The calculation of projected losses and expenses shall be reflected in a written actuarial report that projects ultimate liabilities of the private self-insured employer at the expected actuarial confidence level ~~or of the private group self-insurer by program year at the 80-percent actuarial confidence level~~, to ensure that all claims and associated costs are recognized. The written actuarial report shall be prepared by an actuary meeting the qualifications prescribed by the director in regulation.

(d) In determining the amount of the deposit required to secure incurred liabilities for the payment of compensation and the performance of obligations of a self-insured employer imposed under this chapter, the director shall offset estimated future liabilities for the same claims covered by a self-insured plan under the federal Longshore and Harbor Workers' Compensation Act

(33 U.S.C. Sec. 901 et seq.), but in no event shall the offset exceed the estimated future liabilities for the claims under this chapter.

(e) The director may only accept as security, and the employer shall deposit as security, cash, securities, surety bonds, or irrevocable letters of credit in any combination the director, in his or her discretion, deems adequate security. The current deposit shall include any amounts covered by terminated surety bonds or excess insurance policies, as shall be set forth in regulations adopted by the director pursuant to Section 3702.10.

(f) Surety bonds, irrevocable letters of credit, and documents showing issuance of any irrevocable letter of credit shall be deposited with, and be in a form approved by, the director, shall be exonerated only according to its terms and, in no event, by the posting of additional security.

(g) The director may accept as security a joint security deposit that secures an employer's obligation under this chapter and that also secures that employer's obligations under the federal Longshore and Harbor Workers' Compensation Act.

(h) The liability of the Self-Insurers' Security Fund, with respect to any claims brought under both this chapter and under the federal Longshore and Harbor Workers' Compensation Act, to pay for shortfalls in a security deposit shall be limited to the amount of claim liability owing the employee under this chapter offset by the amount of any claim liability owing under the federal Longshore and Harbor Workers' Compensation Act, but in no event shall the liability of the fund exceed the claim liability under this chapter. The employee shall be entitled to pursue recovery under either or both the state and federal programs.

(i) Securities shall be deposited on behalf of the director by the self-insured employer with the Treasurer. Securities shall be accepted by the Treasurer for deposit and shall be withdrawn only upon written order of the director.

(j) Cash shall be deposited in a financial institution approved by the director, and in the account assigned to the director. Cash shall be withdrawn only upon written order of the director.

(k) Upon the sending by the director of a request to renew, request to post, or request to increase or decrease a security deposit, a perfected security interest is created in the private self-insured's assets in favor of the director and the Self-Insurers' Security Fund to the extent of any then unsecured portion of the self-insured's

incurred liabilities. That perfected security interest is transferred to any cash or securities thereafter posted by the private self-insured with the director and is released only upon either of the following:

(1) The acceptance by the director of a surety bond or irrevocable letter of credit for the full amount of the incurred liabilities for the payment of compensation.

(2) The return of cash or securities by the director.

The private self-insured employer loses all right, title, and interest in, and any right to control, all assets or obligations posted or left on deposit as security. The director may liquidate the deposit as provided in Section 3701.5 and apply it to the self-insured employer's incurred liabilities either directly or through the Self-Insurers' Security Fund.

SEC. 12. Section 3701.3 of the Labor Code is amended to read:

3701.3. The director shall return to a private self-insured employer all individual security determined, with the consent of the Self-Insurers' Security Fund, to be in excess of that needed to ensure the administration of the employer's self insuring, including legal fees, and the payment of any future claims. This section shall not apply to any security posted as part of the composite deposit, or to any security turned over to the Self-Insurers' Security Fund following an order of default under Section 3701.5.

SEC. 13. Section 3701.5 of the Labor Code is amended to read:

3701.5. (a) If the director determines that a private self-insured employer has failed to pay workers' compensation as required by this division, the security deposit shall be utilized to administer and pay the employer's compensation obligations.

(b) If the director determines the security deposit has not been immediately made available for the payment of compensation, the director shall determine the method of payment and claims administration as appropriate, which may include, but is not limited to, payment by a surety that issued the bond, or payment by an issuer of an irrevocable letter of credit, and administration by a surety or by an adjusting agency, or through the Self-Insurers' Security Fund, or any combination thereof. If the director arranges for administration and payment by any person other than the Self-Insurers' Security Fund after a default is declared, the fund shall have no responsibility for claims administration or payment of the claims.

(c) If the director determines the payment of benefits and claims administration shall be made through the Self-Insurers' Security Fund, the fund shall commence payment of the private self-insured employer's obligations for which it is liable under Section 3743 within 30 days of notification. Payments shall be made to claimants whose entitlement to benefits can be ascertained by the fund, with or without proceedings before the appeals board. Upon the assumption of obligations by the fund pursuant to the director's determination, the fund shall have a right to immediate possession of any posted security and the custodian, surety, or issuer of any irrevocable letter of credit shall turn over the security to the fund together with the interest that has accrued since the date of the self-insured employer's default or insolvency.

(d) The payment of benefits by the Self-Insurers' Security Fund from security deposit proceeds shall release and discharge any custodian of the security deposit, surety, any issuer of a letter of credit, and the self-insured employer, from liability to fulfill obligations to provide those same benefits as compensation, but does not release any person from any liability to the fund for full reimbursement. Payment by a surety constitutes a full release of the surety's liability under the bond to the extent of that payment, and entitles the surety to full reimbursement by the principal or his or her estate. Full reimbursement includes necessary attorney fees and other costs and expenses, without prior claim or proceedings on the part of the injured employee or other beneficiaries. Any decision or determination made, or any settlement approved, by the director or by the appeals board under subdivision (f) shall conclusively be presumed valid and binding as to any and all known claims arising out of the underlying dispute, unless an appeal is made within the time limit specified in Section 5950.

(e) The director shall advise the Self-Insurers' Security Fund promptly after receipt of information indicating that a private self-insured employer may be unable to meet its compensation obligations. The director shall also advise the Self-Insurers' Security Fund of all determinations and directives made or issued pursuant to this section. All financial, actuarial, or claims information received by the director from any self-insurer may be shared by the director with the Self-Insurers' Security Fund.

(f) Disputes concerning the posting, renewal, termination, exoneration, or return of all or any portion of the security deposit, or any liability arising out of the posting or failure to post security, or adequacy of the security or reasonableness of administrative costs, including legal fees, and arising between or among a surety, the issuer of an agreement of assumption and guarantee of workers' compensation liabilities, the issuer of a letter of credit, any custodian of the security deposit, a self-insured employer, or the Self-Insurers' Security Fund shall be resolved by the director. An appeal from the director's decision or determination may be taken to the appropriate superior court by petition for writ of mandate. Payment of claims from the security deposit or by the Self-Insurers' Security Fund shall not be stayed pending the resolution of the disputes unless and until the superior court issues a determination staying a payment of claims decision or determination of the director.

SEC. 14. Section 3701.7 of the Labor Code is amended to read:

3701.7. Where any employer requesting coverage under a new or existing certificate of consent to self-insure has had a period of unlawful uninsurance, either for an applicant in its entirety or for a subsidiary or member of a joint powers authority legally responsible for its own workers' compensation obligations, the following special conditions shall apply before the director may determine if the requesting employer can operate under a certificate of consent to self-insure:

(a) The director may require a deposit of not less than 200 percent of the outstanding liabilities remaining unpaid at the time of application, which had been incurred during the uninsurance period.

(b) At the discretion of the director, where a public or private employer has been previously totally uninsured for workers' compensation pursuant to Section 3700, the director may require an additional deposit not to exceed 100 percent of the total outstanding liabilities for the uninsured period, or the sum of two hundred fifty thousand dollars ($250,000), whichever is greater.

(c) In addition to the deposits required by subdivisions (a) and (b), a penalty shall be paid to the Uninsured Employers Fund of 10 percent per year of the remaining unpaid liabilities, for every year liabilities remain outstanding. In addition, an additional application fee, not to exceed one thousand dollars ($1,000), plus

assessments, pursuant to Section 3702.5 and subdivision (b) of Section 3745, may be imposed by the director and the Self-Insurers' Security Fund, respectively, against private self-insured employers.

(d) A certificate of consent to self-insure shall not be granted to an applicant that has had a period of unlawful uninsurance without the written approval of the Self-Insurers' Security Fund.

(e) An employer may retrospectively insure the outstanding liabilities arising out of the uninsured period, either before or after an application for self-insurance has been approved. Upon proof of insurance acceptable to the director, no deposit shall be required for the period of uninsurance.

The penalties to be paid to the Uninsured Employers Fund shall consist of a one-time payment of 20 percent of the outstanding liabilities for the period of uninsurance remaining unpaid at the time of application, in lieu of any other penalty for being unlawfully uninsured pursuant to this code.

(f) In the case of a subsidiary which meets all of the following conditions, a certificate shall issue without penalty:

(1) The subsidiary has never had a certificate revoked for reasons set forth in Section 3702.

(2) Employee injuries were reported to the Office of Self-Insurance Plans in annual reports.

(3) The security deposit of the certificate holder was calculated to include the entity's compensation liabilities.

(4) Application for a separate certificate or corrected certificate is made within 90 days and completed within 180 days of notice from the Office of Self-Insurance Plans. If the requirements of this subdivision are not met, all penalties pursuant to subdivision (b) of Section 3702.9 shall apply.

(g) The director may approve an application on the date the application is substantially completed, subject to completion requirements, and may make the certificate effective on an earlier date, covering a period of uninsurance, if the employer complies with the requirements of this section.

(h) Any decision by the director may be contested by an entity in the manner provided in Section 3701.5.

(i) Nothing in this section shall abrogate the right of an employee to bring an action against an uninsured employer pursuant to Section 3706.

(j) Nothing in this statute shall abrogate the right of a self-insured employer to insure against known or unknown claims arising out of the self-insurance period.

SEC. 15. Section 3701.8 of the Labor Code is amended to read:

3701.8. (a) As an alternative to each private self-insuring employer securing its own incurred liabilities as provided in Section 3701, the director may provide by regulation for an alternative security system whereby all private self-insureds designated for full participation by the director shall collectively secure their aggregate incurred liabilities through the Self-Insurers' Security Fund. The regulations shall provide for the director to set a total security requirement for these participating self-insured employers based on a review of their annual reports and any other self-insurer information as may be specified by the director. The Self-Insurers' Security Fund shall propose to the director a combination of cash and securities, surety bonds, irrevocable letters of credit, insurance, or other financial instruments or guarantees satisfactory to the director sufficient to meet the security requirement set by the director. Upon approval by the director and posting by the Self-Insurers' Security Fund on or before the date set by the director, that combination shall be the composite deposit. The noncash elements of the composite deposit may be one-year or multiple-year instruments. If the Self-Insurers' Security Fund fails to post the required composite deposit by the date set by the director, then within 30 days after that date, each private self-insuring employer shall secure its incurred liabilities in the manner required by Section 3701. Self-insured employers not designated for full participation by the director shall meet all requirements as may be set by the director pursuant to subdivision (g).

(b) In order to provide for the composite deposit approved by the director, the Self-Insurers' Security Fund shall assess, in a manner approved by the director, each fully participating private self-insuring employer a deposit assessment payable within 30 days of assessment. The amount of the deposit assessment charged each fully participating self-insured employer shall be set by the Self-Insurers' Security Fund, based on its reasonable consideration of all the following factors:

(1) The total amount needed to provide the composite deposit.

(2) The self-insuring employer's paid or incurred liabilities as reflected in its annual report.

(3) The financial strength and creditworthiness of the self-insured.

(4) Any other reasonable factors as may be authorized by regulation.

(5) In order to make a composite deposit proposal to the director and set the deposit assessment to be charged each fully participating self-insured, the Self-Insurers' Security Fund shall have access to the annual reports and other information submitted by all self-insuring employers to the director, under terms and conditions as may be set by the director, to preserve the confidentiality of the self-insured's financial information.

(c) Upon payment of the deposit assessment and except as provided herein, the self-insuring employer loses all right, title, and interest in the deposit assessment. To the extent that in any one year the deposit assessment paid by self-insurers is not exhausted in the purchase of securities, surety bonds, irrevocable letters of credit, insurance, or other financial instruments to post with the director as part of the composite deposit, the surplus shall remain posted with the director, and the principal and interest earned on that surplus shall remain as part of the composite deposit in subsequent years. In the event that in any one year the Self-Insurers' Security Fund fails to post the required composite deposit by the date set the by the director, and the director requires each private self-insuring employer to secure its incurred liabilities in the manner required by Section 3701, then any deposit assessment paid in that year shall be refunded to the self-insuring employer that paid the deposit assessment.

(d) If any private self-insuring employer objects to the calculation, posting, or any other aspect of its deposit assessment, upon payment of the assessment in the time provided, the employer shall have the right to appeal the assessment to the director, who shall have exclusive jurisdiction over this dispute. If any private self-insuring employer fails to pay the deposit assessment in the time provided, the director shall order the self-insuring employer to pay a penalty of not less than 10 percent of its deposit assessment, plus interest on any unpaid amount at the prejudgment rate, and to post a separate security deposit in the manner provided by Section 3701. The penalty and interest shall be paid directly to

the Self-Insurers' Security Fund. The director may also revoke the certificate of consent to self-insure of any self-insuring employer who fails to pay the deposit assessment in the time provided.

(e) Upon the posting by the Self-Insurers' Security Fund of the composite deposit with the director, the deposit shall be held until the director determines that a private self-insured employer has failed to pay workers' compensation as required by this division, and the director orders the Self-Insurers' Security Fund to commence payment. Upon ordering the Self-Insurers' Security Fund to commence payment, the director shall make available to the fund that portion of the composite deposit necessary to pay the workers' compensation benefits of the defaulting self-insuring employer. In the event additional funds are needed in subsequent years to pay the workers' compensation benefits of any self-insuring employer who defaulted in earlier years, the director shall make available to the Self-Insurers' Security Fund any portions of the composite deposit as may be needed to pay those benefits. In making the deposit available to the Self-Insurers' Security Fund, the director shall also allow any amounts as may be reasonably necessary to pay for the administrative and other activities of the fund.

(f) The cash portion of the composite deposit shall be segregated from all other funds held by the director, and shall be invested by the director for the sole benefit of the Self-Insurers' Security Fund and the injured workers of private self-insured employers, and may not be used for any other purpose by the state. Alternatively, the director, in his discretion, may allow the Self-Insurers' Security Fund to hold, invest, and draw upon the cash portion of the composite deposit as prescribed by regulation.

(g) Notwithstanding any other provision of this section, the director shall, by regulation, set minimum credit, financial, or other conditions that a private self-insured must meet in order to be a fully participating self-insurer in the alternative security system. In the event any private self-insuring employer is unable to meet the conditions set by the director, or upon application of the Self-Insurers' Security Fund to exclude an employer for credit or financial reasons, the director shall exclude the self-insuring employer from full participation in the alternative security system. In the event a self-insuring employer is excluded from full participation, the nonfully participating private self-insuring

employer shall post a separate security deposit in the manner provided by Section 3701 and pay a deposit assessment set by the director. Alternatively, the director may order that the nonfully participating private self-insuring employer post a separate security deposit to secure a portion of its incurred liabilities and pay a deposit assessment set by the director.

(h) An employer who self-insures through group self-insurance and an employer whose certificate to self-insure has been revoked may fully participate in the alternative security system if both the director and the Self-Insurers' Security Fund approve the participation of the self-insurer. If not approved for full participation, or if an employer is issued a certificate to self-insure after the composite deposit is posted, the employer shall satisfy the requirements of subdivision (g) for nonfully participating private self-insurers.

(i) At all times, a self-insured employer shall have secured its incurred workers' compensation liabilities either in the manner required by Section 3701 or through the alternative security system, and there shall not be any lapse in the security.

SEC. 16. Section 3701.9 is added to the Labor Code, to read:

3701.9. (a) A certificate of consent to self-insure shall not be issued after January 1, 2013, to any of the following:

(1) A professional employer organization.

(2) A leasing employer, as defined in Section 606.5 of the Unemployment Insurance Code.

(3) A temporary services employer, as defined in Section 606.5 of the Unemployment Insurance Code.

(4) Any employer, regardless of name or form of organization, which the director determines to be in the business of providing employees to other employers.

(b) A certificate of consent to self-insure that has been issued to any employer described in subdivision (a) shall be revoked by the director not later than January 1, 2015.

SEC. 17. Section 3702 of the Labor Code is amended to read:

3702. (a) A certificate of consent to self-insure may be revoked by the director at any time for good cause after a hearing. Good cause includes, among other things, a recommendation by the Self-Insurers' Security Fund to revoke the certificate of consent, the impairment of the solvency of the employer to the extent that there is a marked reduction of the employer's financial strength,

failure to maintain a security deposit as required by Section 3701, failure to pay assessments of the Self-Insurers' Security Fund, frequent or flagrant violations of state safety and health orders, the failure or inability of the employer to fulfill his or her obligations, or any of the following practices by the employer or his or her agent in charge of the administration of obligations under this division:

(1) Habitually and as a matter of practice and custom inducing claimants for compensation to accept less than the compensation due or making it necessary for them to resort to proceedings against the employer to secure compensation due.

(2) Where liability for temporary disability indemnity is not in dispute, intentionally failing to pay temporary disability indemnity without good cause in order to influence the amount of permanent disability benefits due.

(3) Intentionally refusing to comply with known and legally indisputable compensation obligations.

(4) Discharging or administering his or her compensation obligations in a dishonest manner.

(5) Discharging or administering his or her compensation obligations in such a manner as to cause injury to the public or those dealing with the employer.

(b) Where revocation is in part based upon the director's finding of a marked reduction of the employer's financial strength or the failure or inability of the employer to fulfill his or her obligations, or a practice of discharging obligations in a dishonest manner, it is a condition precedent to the employer's challenge or appeal of the revocation that the employer have in effect insurance against liability to pay compensation.

(c) The director may hold a hearing to determine whether good cause exists to revoke an employer's certificate of consent to self-insure if the employer is cited for a willful, or repeat serious violation of the standard adopted pursuant to Section 6401.7 and the citation has become final.

SEC. 18. Section 3702.2 of the Labor Code is amended to read:

3702.2. (a) All self-insured employers shall file a self-insurer's annual report in a form prescribed by the director. Public self-insured employers shall provide detailed information as the director determines necessary to evaluate the costs of administration, workers' compensation benefit expenditures, and

solvency and performance of the public self-insured employer workers' compensation programs, on a schedule established by the director. The director may grant deferrals to public self-insured employers that are not yet capable of accurately reporting the information required, giving priority to bringing larger programs into compliance with the more detailed reporting.

(b) To enable the director to determine the amount of the security deposit required by subdivision (c) of Section 3701, the annual report of a self-insured employer who has self-insured both state and federal workers' compensation liability shall also set forth (1) the amount of all compensation liability incurred, paid-to-date, and estimated future liability under both this chapter and under the federal Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sec. 901 et seq.), and (2) the identity and the amount of the security deposit securing the employer's liability under state and federal self-insured programs.

(c) The director shall annually prepare an aggregated summary of all self-insured employer liability to pay compensation reported on the self-insurers' employers annual reports, including a separate summary for public and private employer self-insurers. The summaries shall be in the same format as the individual self-insured employers are required to report that liability on the employer self-insurer's annual report forms prescribed by the director. The aggregated summaries shall be made available to the public on the self-insurance section of the department's Internet Web site. Nothing in this subdivision shall authorize the director to release or make available information that is aggregated by industry or business type, that identifies individual self-insured filers, or that includes any individually identifiable claimant information.

(d) The director may release a copy, or make available an electronic version, of the data contained in any public sector employer self-insurer's annual reports received from an individual public entity self-insurer or from a joint powers authority employer and its membership. However, the release of any annual report information by the director shall not include any portion of any listing of open indemnity claims that contains individually identifiable claimant information, or any portion of excess insurance coverage information that contains any individually identifiable claimant information.

SEC. 19. Section 3702.4 is added to the Labor Code, to read:

3702.4. (a) The Commission on Health and Safety and Workers' Compensation shall conduct an examination of the public self-insured program and publish, on its Internet Web site, a preliminary draft report and recommendations for improvement of the program no later than October 1, 2013, and a final report no later than December 31, 2013. The recommendations shall address costs of administration, workers' compensation benefit expenditures, and solvency and performance of public self-insured workers' compensation programs, as well as provisions in the event of insolvencies.

(b) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 20. Section 3702.5 of the Labor Code is amended to read:

3702.5. (a) (1) The cost of administration of the public self-insured program by the Director of Industrial Relations shall be borne by the Workers' Compensation Administration Revolving Fund.

(2) The cost of administration of the private self-insured program by the Director of Industrial Relations shall be borne by the private self-insurers through payment of certificate fees which shall be established by the director in broad ranges based on the comparative numbers of employees insured by the private self-insurers and the number of adjusting locations. The director may assess other fees as necessary to cover the costs of special audits or services rendered to private self-insured employers. The director may assess a civil penalty for late filing as set forth in subdivision (a) of Section 3702.9.

(b) All revenues from fees and penalties paid by private self-insured employers shall be deposited into the Self-Insurance Plans Fund, which is hereby created for the administration of the private self-insurance program. Any unencumbered balance in subdivision (a) of Item 8350-001-001 of the Budget Act of 1983 shall be transferred to the Self-Insurance Plans Fund. The director shall annually eliminate any unused surplus in the Self-Insurance Plans Fund by reducing certificate fee assessments by an appropriate amount in the subsequent year. Moneys paid into the Self-Insurance Plans Fund for administration of the private self-insured program shall not be used by any other department or agency or for any purpose other than administration of the private

self-insurance program. Detailed accountability shall be maintained by the director for any security deposit or other funds held in trust for the Self-Insurer's Security Fund in the Self-Insurance Plans Fund.

Moneys held by the director shall be invested in the Surplus Money Investment Fund. Interest shall be paid on all moneys transferred to the General Fund in accordance with Section 16310 of the Government Code. The Treasurer's and Controller's administrative costs may be charged to the interest earnings upon approval of the director.

SEC. 21. Section 3702.8 of the Labor Code is amended to read:

3702.8. (a) Employers who have ceased to be self-insured employers shall discharge their continuing obligations to secure the payment of workers' compensation that accrued during the period of self-insurance, for purposes of Sections 3700, 3700.5, 3706, and 3715, and shall comply with all of the following obligations of current certificate holders:

(1) Filing annual reports as deemed necessary by the director to carry out the requirements of this chapter.

(2) In the case of a private employer, depositing and maintaining a security deposit for accrued liability for the payment of any workers' compensation that may become due, pursuant to subdivision (b) of Section 3700 and Section 3701, except as provided in subdivision (c).

(3) Paying within 30 days all assessments of which notice is sent, pursuant to subdivision (b) of Section 3745, within 36 months from the last day the employer's certificate of self-insurance was in effect. Assessments shall be based on the benefits paid by the employer during the last full calendar year of self-insurance on claims incurred during that year.

(b) In addition to proceedings to establish liabilities and penalties otherwise provided, a failure to comply may be the subject of a proceeding before the director. An appeal from the director's determination shall be taken to the appropriate superior court by petition for writ of mandate.

(c) Notwithstanding subdivision (a), any employer who is currently self-insured or who has ceased to be self-insured may purchase a special excess workers' compensation policy to discharge any or all of the employer's continuing obligations as a

self-insurer to pay compensation or to secure the payment of compensation.

(1) The special excess workers' compensation insurance policy shall be issued by an insurer authorized to transact workers' compensation insurance in this state.

(2) Each carrier's special excess workers' compensation policy shall be approved as to form and substance by the Insurance Commissioner, and rates for special excess workers' compensation insurance shall be subject to the filing requirements set forth in Section 11735 of the Insurance Code.

(3) Each special excess workers' compensation insurance policy shall be submitted by the employer to the director. The director shall adopt and publish minimum insurer financial rating standards for companies issuing special excess workers' compensation policies.

(4) Upon acceptance by the director, a special excess workers' compensation policy shall provide coverage for all or any portion of the purchasing employer's claims for compensation arising out of injuries occurring during the period the employer was self-insured in accordance with Sections 3755, 3756, and 3757 of the Labor Code and Sections 11651 and 11654 of the Insurance Code. The director's acceptance shall discharge the Self-Insurer's Security Fund, without recourse or liability to the Self-Insurer's Security Fund, of any continuing liability for the claims covered by the special excess workers' compensation insurance policy.

(5) For public employers, no security deposit or financial guarantee bond or other security shall be required. The director shall set minimum financial rating standards for insurers issuing special excess workers' compensation policies for public employers.

(d) (1) In order for the special excess workers' compensation insurance policy to discharge the full obligations of a private employer to maintain a security deposit with the director for the payment of self-insured claims, applicable to the period to be covered by the policy, the special excess policy shall provide coverage for all claims for compensation arising out of that liability. The employer shall maintain the required deposit for the period covered by the policy with the director for a period of three years after the issuance date of the special excess policy.

(2) If the special workers' compensation insurance policy does not provide coverage for all of the continuing obligations for which the private self-insured employer is liable, to the extent the employer's obligations are not covered by the policy a private employer shall maintain the required deposit with the director. In addition, the employer shall maintain with the director the required deposit for the period covered by the policy for a period of three years after the issuance date of the special excess policy.

(e) The director shall adopt regulations pursuant to Section 3702.10 that are reasonably necessary to implement this section in order to reasonably protect injured workers, employers, the Self-Insurers' Security Fund, and the California Insurance Guarantee Association.

(f) The posting of a special excess workers' compensation insurance policy with the director shall discharge the obligation of the Self-Insurer's Security Fund pursuant to Section 3744 to pay claims in the event of an insolvency of a private employer to the extent of coverage of compensation liabilities under the special excess workers' compensation insurance policy. The California Insurance Guarantee Association and the Self-Insurers' Security Fund shall be advised by the director whenever a special excess workers' compensation insurance policy is posted.

SEC. 22. Section 3702.10 of the Labor Code is amended to read:

3702.10. The director, in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, may adopt, amend, and repeal rules and regulations reasonably necessary to carry out the purposes of Section 129 and Article 1 (commencing with Section 3700), Article 2 (commencing with Section 3710), and Article 2.5 (commencing with Section 3740). This authorization includes, but is not limited to, the adoption of regulations to do all of the following:

(a) Specifying what constitutes ability to self-insure and to pay any compensation which may become due under Section 3700.

(b) Specifying what constitutes a marked reduction of an employer's financial strength.

(c) Specifying what constitutes a failure or inability to fulfill the employer's obligations under Section 3702.

(d) Interpreting and defining the terms used.

(e) Establishing procedures and standards for hearing and determinations, and providing for those determinations to be appealed to the appeals board.

(f) Specifying the standards, form, and content of agreements, forms, and reports between parties who have obligations pursuant to this chapter.

(g) Providing for the combinations and relative liabilities of security deposits, assumptions, and guarantees used pursuant to this chapter.

(h) Disclosing otherwise confidential financial information concerning self-insureds to courts or the Self-Insurers' Security Fund and specifying appropriate safeguards for that information.

(i) Requiring an amount to be added to each security deposit to secure the cost of administration of claims and to pay all legal costs.

(j) Regulating the workers' compensation self-insurance obligations of self-insurance groups and professional ~~employee~~ *employer* organizations, leasing employers as defined in Section 606.5 of the Unemployment Insurance Code, or temporary services employers, as defined in Section 606.5 of the Unemployment Insurance Code, holding certificates of consent to self-insure.

SEC. 23. Section 3742 of the Labor Code is amended to read:

3742. (a) The Self-Insurers' Security Fund shall be established as a Nonprofit Mutual Benefit Corporation pursuant to Part 3 (commencing with Section 7110) of Division 2 of Title 1 of the Corporations Code and this article. If any provision of the Nonprofit Mutual Benefit Corporation Law conflicts with any provision of this article, the provisions of this article shall apply. Each private self-insurer shall participate as a member in the fund, unless its liabilities have been turned over to the fund pursuant to Section 3701.5, at which time its membership in the fund is relinquished.

(b) The fund shall be governed by a board of trustees with no more than eight members, as established by the bylaws of the Self-Insurers' Security Fund. The director shall hold ex officio status, with full powers equal to those of a trustee, except that the director shall not have a vote. The director, or a delegate authorized in writing to act as the director's representative on the board of trustees, shall carry out exclusively the responsibilities set forth in Division 1 (commencing with Section 50) through Division 4

(commencing with Section 3200) and shall not have the obligations of a trustee under the Nonprofit Mutual Benefit Corporation Law. The fund shall adopt bylaws to segregate the director from all matters that may involve fund litigation against the department or fund participation in legal proceedings before the director. Although not voting, the director or a delegate authorized in writing to represent the director, shall be counted toward a quorum of trustees. The remaining trustees shall be representatives of private self-insurers. The self-insurer trustees shall be elected by the members of the fund, each member having one vote. Trustees shall be elected to four-year terms, and shall serve until their successors are elected and assume office pursuant to the bylaws of the fund.

(c) The fund shall establish bylaws as are necessary to effectuate the purposes of this article and to carry out the responsibilities of the fund, including, but not limited to, any obligations imposed by the director pursuant to Section 3701.8. The fund may carry out its responsibilities directly or by contract, and may purchase services and insurance and borrow funds as it deems necessary for the protection of the members and their employees. The fund may receive confidential information concerning the financial condition of self-insured employers whose liabilities to pay compensation may devolve upon it and shall adopt bylaws to prevent dissemination of that information.

(d) The director may also require fund members to subscribe to financial instruments or guarantees to be posted with the director in order to satisfy the security requirements set by the director pursuant to Section 3701.8.

SEC. 24. Section 3744 of the Labor Code is amended to read:

3744. (a) *(1)* The fund shall have the right and obligation to obtain reimbursement from an insolvent self-insurer up to the amount of the self-insurer's workers' compensation obligations paid and assumed by the fund, including reasonable administrative and legal costs. This right includes, but is not limited to, a right to claim for wages and other necessities of life advanced to claimants as subrogee of the claimants in any action to collect against the self-insured as debtor. For purposes of this section, "insolvent self-insurer" includes the entity to which the certificate of consent to self-insure was issued, any guarantor of the entity's liabilities under the certificate, any member of a self-insurance group to which the certificate was issued, and any employer who obtained

employees from a self-insured employer under subdivision (d) of Section 3602.

(2) The Legislature finds and declares that the amendments made to this subdivision by the act adding this paragraph are declaratory of existing law.

(b) The fund shall have the right and obligation to obtain from the security deposit of an insolvent self-insurer the amount of the self-insurer's compensation obligations, including reasonable administrative and legal costs, paid or assumed by the fund. Reimbursement of administrative costs, including legal costs, shall be subject to approval by a majority vote of the fund's trustees. The fund shall be a party in interest in any action to obtain the security deposit for the payment of compensation obligations of an insolvent self-insurer.

(c) The fund shall have the right to bring an action against any person to recover compensation paid and liability assumed by the fund, including, but not limited to, any excess insurance carrier of the self-insured employer, and any person whose negligence or breach of any obligation contributed to any underestimation of the self-insured employer's total accrued liability as reported to the director.

(d) The fund may be a party in interest in any action brought by any other person seeking damages resulting from the failure of an insolvent self-insurer to pay workers' compensation required pursuant to this division.

(e) At the election of the Self-Insurers' Security Fund, venue shall be in the Superior Court for the State of California, County of Sacramento, for any action under this section. All actions in which the Self-Insurers' Security Fund and two or more members or former members of one self-insurance group are parties shall be consolidated if requested by the Self-Insurers' Security Fund.

SEC. 25. Section 3745 of the Labor Code is amended to read:

3745. (a) The fund shall maintain cash, readily marketable securities, or other assets, or a line of credit, approved by the director, sufficient to immediately continue the payment of the compensation obligations of an insolvent self-insurer pending assessment of the members. The director may establish the minimum amount to be maintained by, or immediately available to, the fund for this purpose.

(b) The fund may assess each of its members a pro rata share of the funding necessary to carry out the purposes of this article.

(c) The trustees shall certify to the director the collection and receipt of all moneys from assessments, noting any delinquencies. The trustees shall take any action deemed appropriate to collect any delinquent assessments.

SEC. 26. Section 3746 of the Labor Code is amended to read:

3746. The fund shall annually contract for an independent certified audit of the financial activities of the fund. An annual report on the financial status of the fund as of June 30 shall be submitted to the director and to each member, or at the election of the fund, posted on the fund's Internet Web site.

SEC. 27. 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 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 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 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. 28. Section 4062 of the Labor Code is amended to read:

4062. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical

evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained.

(b) If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a request for authorization of a medical treatment recommendation made by a treating physician, the objection shall be resolved only in accordance with the independent medical review process established in Section 4610.5.

(c) If the employee objects to the diagnosis or recommendation for medical treatment by a physician within the employer's medical provider network established pursuant to Section 4616, the objection shall be resolved only in accordance with the independent medical review process established in Sections 4616.3 and 4616.4.

SEC. 29. Section 4062.2 of the Labor Code is amended to read:

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

(b) No earlier than the first working day that is at least 10 days after the date of mailing of a request for a medical evaluation pursuant to Section 4060 or the first working day that is at least 10 days after the date of mailing of an objection pursuant to Sections 4061 or 4062, either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation. The party submitting the request shall designate the specialty of the medical evaluator, the specialty of the medical evaluator requested by the other party if it has been made known to the party submitting the request, and the specialty of the treating physician. The party submitting the request form shall serve a copy of the request form on the other party.

(c) Within 10 days of assignment of the panel by the administrative director, each party may strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator. If a party fails to exercise the right to strike

a name from the panel within 10 days of assignment of the panel by the administrative director, the other party may select any physician who remains on the panel to serve as the medical evaluator. The administrative director may prescribe the form, the manner, or both, by which the parties shall conduct the selection process.

(d) The represented employee shall be responsible for arranging the appointment for the examination, but upon his or her failure to inform the employer of the appointment within 10 days after the medical evaluator has been selected, the employer may arrange the appointment and notify the employee of the arrangements. The employee shall not unreasonably refuse to participate in the evaluation.

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

(f) The parties may agree to an agreed medical evaluator at any time, except as to issues subject to the independent medical review process established pursuant to Section 4610.5. A panel shall not be requested pursuant to subdivision (b) on any issue that has been agreed to be submitted to or has been submitted to an agreed medical evaluator unless the agreement has been canceled by mutual written consent.

SEC. 30. Section 4062.3 of the Labor Code is amended to read:

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

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

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

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

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

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

(1) All information received from the parties.

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

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

(e) All communications with a qualified medical evaluator selected from a panel before a medical evaluation shall be in writing and shall be served on the opposing party 20 days in advance of the evaluation. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party when sent to the medical evaluator.

(f) Communications with an agreed medical evaluator shall be in writing, and shall be served on the opposing party when sent to the agreed medical evaluator. Oral or written communications with physician staff or, as applicable, with the agreed medical evaluator, relative to nonsubstantial matters such as the scheduling of appointments, missed appointments, the furnishing of records and reports, and the availability of the report, do not constitute ex parte communication in violation of this section unless the appeals board has made a specific finding of an impermissible ex parte communication.

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

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

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

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

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

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

SEC. 31. Section 4063 of the Labor Code is amended to read:

4063. If a formal medical evaluation from 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, except as provided pursuant to paragraph (2) of subdivision (b) of Section 4650, commence the payment of compensation or file a declaration of readiness to proceed.

SEC. 32. Section 4064 of the Labor Code is amended to read:

4064. (a) The employer shall be liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee pursuant to Sections 4060, 4061, and 4062. Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms, except medical treatment recommendations, which are subject to utilization review as provided by Section 4610, and objections to utilization review determinations, which are subject to independent medical review as provided by Section 4610.5.

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

(c) Subject to Section 4906, if an employer files a declaration of readiness to proceed and the employee is unrepresented at the time the declaration of readiness to proceed is filed, the employer shall be liable for any attorney's fees incurred by the employee in connection with the declaration of readiness to proceed.

(d) The employer shall not be liable for the cost of any comprehensive medical evaluations obtained by the employee other than those authorized pursuant to Sections 4060, 4061, and 4062. However, no party is prohibited from obtaining any medical evaluation or consultation at the party's own expense. In no event shall an employer or employee be liable for an evaluation obtained in violation of subdivision (b) of Section 4060. All comprehensive medical evaluations obtained by any party shall be admissible in any proceeding before the appeals board except as provided in Section 4060, 4061, 4062, 4062.1, or 4062.2.

SEC. 33. Section 4066 of the Labor Code is repealed.

SEC. 34. Section 4453 of the Labor Code is amended to read:

4453. (a) In computing average annual earnings for the purposes of temporary disability indemnity and permanent total disability indemnity only, the average weekly earnings shall be taken at:

(1) Not less than one hundred twenty-six dollars ($126) nor more than two hundred ninety-four dollars ($294), for injuries occurring on or after January 1, 1983.

(2) Not less than one hundred sixty-eight dollars ($168) nor more than three hundred thirty-six dollars ($336), for injuries occurring on or after January 1, 1984.

(3) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and, for temporary disability, not less than the lesser of one hundred sixty-eight dollars ($168) or 1.5 times the employee's average weekly earnings from all employers, but in no event less than one hundred forty-seven dollars ($147),

nor more than three hundred ninety-nine dollars ($399), for injuries occurring on or after January 1, 1990.

(4) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars ($189) or 1.5 times the employee's average weekly earnings from all employers, nor more than five hundred four dollars ($504), for injuries occurring on or after January 1, 1991.

(5) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars ($189) or 1.5 times the employee's average weekly earnings from all employers, nor more than six hundred nine dollars ($609), for injuries occurring on or after July 1, 1994.

(6) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars ($189) or 1.5 times the employee's average weekly earnings from all employers, nor more than six hundred seventy-two dollars ($672), for injuries occurring on or after July 1, 1995.

(7) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars ($189) or 1.5 times the employee's average weekly earnings from all employers, nor more than seven hundred thirty-five dollars ($735), for injuries occurring on or after July 1, 1996.

(8) Not less than one hundred eighty-nine dollars ($189), nor more than nine hundred three dollars ($903), for injuries occurring on or after January 1, 2003.

(9) Not less than one hundred eighty-nine dollars ($189), nor more than one thousand ninety-two dollars ($1,092), for injuries occurring on or after January 1, 2004.

(10) Not less than one hundred eighty-nine dollars ($189), nor more than one thousand two hundred sixty dollars ($1,260), for injuries occurring on or after January 1, 2005. For injuries occurring on or after January 1, 2006, average weekly earnings shall be taken at not less than one hundred eighty-nine dollars ($189), nor more than one thousand two hundred sixty dollars ($1,260) or 1.5 times the state average weekly wage, whichever is greater. Commencing on January 1, 2007, and each January 1

thereafter, the limits specified in this paragraph shall be increased by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year. For purposes of this paragraph, "state average weekly wage" means the average weekly wage paid by employers to employees covered by unemployment insurance as reported by the United States Department of Labor for California for the 12 months ending March 31 of the calendar year preceding the year in which the injury occurred.

(b) In computing average annual earnings for purposes of permanent partial disability indemnity, except as provided in Section 4659, the average weekly earnings shall be taken at:

(1) Not less than seventy-five dollars ($75), nor more than one hundred ninety-five dollars ($195), for injuries occurring on or after January 1, 1983.

(2) Not less than one hundred five dollars ($105), nor more than two hundred ten dollars ($210), for injuries occurring on or after January 1, 1984.

(3) When the final adjusted permanent disability rating of the injured employee is 15 percent or greater, but not more than 24.75 percent: (A) not less than one hundred five dollars ($105), nor more than two hundred twenty-two dollars ($222), for injuries occurring on or after July 1, 1994; (B) not less than one hundred five dollars ($105), nor more than two hundred thirty-one dollars ($231), for injuries occurring on or after July 1, 1995; (C) not less than one hundred five dollars ($105), nor more than two hundred forty dollars ($240), for injuries occurring on or after July 1, 1996.

(4) When the final adjusted permanent disability rating of the injured employee is 25 percent or greater, not less than one hundred five dollars ($105), nor more than two hundred twenty-two dollars ($222), for injuries occurring on or after January 1, 1991.

(5) When the final adjusted permanent disability rating of the injured employee is 25 percent or greater but not more than 69.75 percent: (A) not less than one hundred five dollars ($105), nor more than two hundred thirty-seven dollars ($237), for injuries occurring on or after July 1, 1994; (B) not less than one hundred five dollars ($105), nor more than two hundred forty-six dollars ($246), for injuries occurring on or after July 1, 1995; and (C) not less than one hundred five dollars ($105), nor more than two hundred fifty-five dollars ($255), for injuries occurring on or after July 1, 1996.

(6) When the final adjusted permanent disability rating of the injured employee is less than 70 percent: (A) not less than one hundred fifty dollars ($150), nor more than two hundred seventy-seven dollars and fifty cents ($277.50), for injuries occurring on or after January 1, 2003; (B) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than three hundred dollars ($300), for injuries occurring on or after January 1, 2004; (C) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than three hundred thirty dollars ($330), for injuries occurring on or after January 1, 2005; and (D) not less than one hundred ninety-five dollars ($195), nor more than three hundred forty-five dollars ($345), for injuries occurring on or after January 1, 2006.

(7) When the final adjusted permanent disability rating of the injured employee is 70 percent or greater, but less than 100 percent: (A) not less than one hundred five dollars ($105), nor more than two hundred fifty-two dollars ($252), for injuries occurring on or after July 1, 1994; (B) not less than one hundred five dollars ($105), nor more than two hundred ninety-seven dollars ($297), for injuries occurring on or after July 1, 1995; (C) not less than one hundred five dollars ($105), nor more than three hundred forty-five dollars ($345), for injuries occurring on or after July 1, 1996; (D) not less than one hundred fifty dollars ($150), nor more than three hundred forty-five dollars ($345), for injuries occurring on or after January 1, 2003; (E) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than three hundred seventy-five dollars ($375), for injuries occurring on or after January 1, 2004; (F) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than four hundred five dollars ($405), for injuries occurring on or after January 1, 2005; and (G) not less than one hundred ninety-five dollars ($195), nor more than four hundred five dollars ($405), for injuries occurring on or after January 1, 2006.

(8) For injuries occurring on or after January 1, 2013:

(A) When the final adjusted permanent disability rating is less than 55 percent, not less than two hundred forty dollars ($240) nor more than three hundred forty-five dollars ($345).

(B) When the final adjusted permanent disability rating is 55 percent or greater but less than 70 percent, not less than two

hundred forty dollars ($240) nor more than four hundred five dollars ($405).

(C) When the final adjusted permanent disability rating is 70 percent or greater but less than 100 percent, not less than two hundred forty dollars ($240) nor more than four hundred thirty-five dollars ($435).

(9) For injuries occurring on or after January 1, 2014, not less than two hundred forty dollars ($240) nor more than four hundred thirty-five dollars ($435).

(c) Between the limits specified in subdivisions (a) and (b), the average weekly earnings, except as provided in Sections 4456 to 4459, shall be arrived at as follows:

(1) Where the employment is for 30 or more hours a week and for five or more working days a week, the average weekly earnings shall be the number of working days a week times the daily earnings at the time of the injury.

(2) Where the employee is working for two or more employers at or about the time of the injury, the average weekly earnings shall be taken as the aggregate of these earnings from all employments computed in terms of one week; but the earnings from employments other than the employment in which the injury occurred shall not be taken at a higher rate than the hourly rate paid at the time of the injury.

(3) If the earnings are at an irregular rate, such as piecework, or on a commission basis, or are specified to be by week, month, or other period, then the average weekly earnings mentioned in subdivision (a) shall be taken as the actual weekly earnings averaged for this period of time, not exceeding one year, as may conveniently be taken to determine an average weekly rate of pay.

(4) Where the employment is for less than 30 hours per week, or where for any reason the foregoing methods of arriving at the average weekly earnings cannot reasonably and fairly be applied, the average weekly earnings shall be taken at 100 percent of the sum which reasonably represents the average weekly earning capacity of the injured employee at the time of his or her injury, due consideration being given to his or her actual earnings from all sources and employments.

(d) Every computation made pursuant to this section beginning January 1, 1990, shall be made only with reference to temporary disability or the permanent disability resulting from an original

injury sustained after January 1, 1990. However, all rights existing under this section on January 1, 1990, shall be continued in force. Except as provided in Section 4661.5, disability indemnity benefits shall be calculated according to the limits in this section in effect on the date of injury and shall remain in effect for the duration of any disability resulting from the injury.

SEC. 35. 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.

(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. 36. Section 4603.2 of the Labor Code is amended to read:

4603.2. (a) (1) Upon selecting a physician pursuant to Section 4600, the employee or physician shall notify the employer of the name and address, including the name of the medical group, if applicable, of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination, as required by Section 6409, and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(2) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was entitled to select the physician pursuant to Section 4600, the employee shall be entitled to continue treatment with that physician at the employer's expense in accordance with this division, notwithstanding Section 4616.2. The employer shall be required to pay from the date of the initial examination if the physician's report was submitted within five

working days of the initial examination. If the physician's report was submitted more than five working days after the initial examination, the employer and the employee shall not be required to pay for any services prior to the date the physician's report was submitted.

(3) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was not entitled to select a physician outside of the medical provider network, the employer shall have no liability for treatment provided by or at the direction of that physician or for any consequences of the treatment obtained outside the network.

(b) (1) Any provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received. Nothing in this section shall prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600.

(2) Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service. Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified,

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

(A) Pays the provider at the rates in effect within the 45-day period.

(B) Advises, in an explanation of review pursuant to Section 4603.3, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of an itemization that includes services provided by a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the itemization shall satisfy the requirements of this paragraph.

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

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

(4) Duplicate submissions of medical services itemizations, for which an explanation of review was previously provided, shall require no further or additional notification or objection by the employer to the medical provider and shall not subject the employer to any additional penalties or interest pursuant to this section for failing to respond to the duplicate submission. This paragraph shall apply only to duplicate submissions and does not apply to any

other penalties or interest that may be applicable to the original submission.

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

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

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

(e) (1) If the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review pursuant to paragraph (5) of subdivision (a) of Section 4603.3. The request

for a second review shall be submitted to the employer on a form prescribed by the administrative director and shall include all of the following:

(A) The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.

(B) The item and amount in dispute.

(C) The additional payment requested and the reason therefor.

(D) The additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.

(2) If the only dispute is the amount of payment and the provider does not request a second review within 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

(3) Within 14 days of a request for second review, the employer shall respond with a final written determination on each of the items or amounts in dispute. Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review. This time limit may be extended by mutual written agreement.

(4) If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6.

(f) Except as provided in paragraph (4) of subdivision (e), the appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

SEC. 37. Section 4603.3 is added to the Labor Code, to read:

4603.3. (a) Upon payment, adjustment, or denial of a complete or incomplete itemization of medical services, an employer shall provide an explanation of review in the manner prescribed by the administrative director that shall include all of the following:

(1) A statement of the items or procedures billed and the amounts requested by the provider to be paid.

(2) The amount paid.

(3) The basis for any adjustment, change, or denial of the item or procedure billed.

(4) The additional information required to make a decision for an incomplete itemization.

(5) If a denial of payment is for some reason other than a fee dispute, the reason for the denial.

(6) Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing. The explanation of review shall inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill pursuant to Section 4603.6.

(b) The administrative director may adopt regulations requiring the use of electronic explanations of review.

SEC. 38. Section 4603.4 of the Labor Code is amended to read:

4603.4. (a) The administrative director shall adopt rules and regulations to do all of the following:

(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.

(2) Require acceptance by employers of electronic claims for payment of medical services.

(3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996.

(c) The rules and regulations requiring employers to accept electronic claims for payment of medical services shall be adopted on or before January 1, 2005, and shall require all employers to accept electronic claims for payment of medical services on or before July 1, 2006.

(d) Payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made with an explanation of review by the employer within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section 5307.1. If the billing is contested, denied, or incomplete, payment shall be made with an explanation of review of any uncontested amounts within 15 working days after electronic receipt of the billing, and payment of the balance shall be made in accordance with Section 4603.2.

SEC. 39. Section 4603.6 is added to the Labor Code, to read:

4603.6. (a) If the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute, the provider may request an independent bill review within 30 calendar days of service of the second review pursuant to Section 4603.2 or 4622. If the provider fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622.

(b) A request for independent review shall be made on a form prescribed by the administrative director, and shall include copies of the original billing itemization, any supporting documents that were furnished with the original billing, the explanation of review, the request for second review together with any supporting documentation submitted with that request, and the final explanation of the second review. The administrative director may require that requests for independent bill review be submitted electronically. A copy of the request, together with all required documents, shall be served on the employer. Only the request form and the proof of payment of the fee required by subdivision (c) shall be filed with the administrative director. Upon notice of assignment of the independent bill reviewer, the requesting party shall submit the documents listed in this subdivision to the independent bill reviewer within 10 days.

(c) The provider shall pay to the administrative director a fee determined by the administrative director to cover no more than the reasonable estimated cost of independent bill review and administration of the independent bill review program. The administrative director may prescribe different fees depending on the number of items in the bill or other criteria determined by regulation adopted by the administrative director. If any additional payment is found owing from the employer to the medical provider, the employer shall reimburse the provider for the fee in addition to the amount found owing.

(d) Upon receipt of a request for independent bill review and the required fee, the administrative director or the administrative

director's designee shall assign the request to an independent bill reviewer within 30 days and notify the medical provider and employer of the independent reviewer assigned.

(e) The independent bill reviewer shall review the materials submitted by the parties and make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination. If the independent bill reviewer deems necessary, the independent bill reviewer may request additional documents from the medical provider or employer. The employer shall have no obligation to serve medical reports on the provider unless the reports are requested by the independent bill reviewer. If additional documents are requested, the parties shall respond with the documents requested within 30 days and shall provide the other party with copies of any documents submitted to the independent reviewer, and the independent reviewer shall make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination within 60 days of the receipt of the administrative director's assignment. The written determination of the independent bill reviewer shall be sent to the administrative director and provided to both the medical provider and the employer.

(f) The determination of the independent bill reviewer shall be deemed a determination and order of the administrative director. The determination is final and binding on all parties unless an aggrieved party files with the appeals board a verified appeal from the medical bill review determination of the administrative director within 20 days of the service of the determination. The medical bill review determination of the administrative director shall be presumed to be correct and shall be set aside only upon clear and convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of his or her powers.

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

(3) The independent bill 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 and not a matter that is subject to expert opinion.

(g) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent bill review by a different independent review organization. In the event that a different independent bill review organization is not available after remand, the administrative director shall submit the dispute to the original bill review organization for review by a different reviewer within the organization. In no event shall the appeals board or any higher court make a determination of ultimate fact contrary to the determination of the bill review organization.

(h) Once the independent bill reviewer has made a determination regarding additional amounts to be paid to the medical provider, the employer shall pay the additional amounts per the timely payment requirements set forth in Sections 4603.2 and 4603.4.

SEC. 40. Section 4604 of the Labor Code is amended to read:

4604. Controversies between employer and employee arising under this chapter shall be determined by the appeals board, upon the request of either party, except as otherwise provided by Section 4610.5.

SEC. 41. Section 4604.5 of the Labor Code is amended to read:

4604.5. (a) The recommended guidelines set forth in the medical treatment utilization schedule adopted by the administrative director pursuant to Section 5307.27 shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence and scientifically based, nationally recognized, and peer reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with

Section 4600 for all injured workers diagnosed with industrial conditions.

(c) (1) Notwithstanding the medical treatment utilization schedule, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.

(2) (A) Paragraph (1) shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services. Payment or authorization for treatment beyond the limits set forth in paragraph (1) shall not be deemed a waiver of the limits set forth by paragraph (1) with respect to future requests for authorization.

(B) The Legislature finds and declares that the amendments made to subparagraph (A) by the act adding this subparagraph are declaratory of existing law.

(3) Paragraph (1) shall not apply to visits for postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27.

(d) For all injuries not covered by the official utilization schedule adopted pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community and scientifically based.

SEC. 42. Section 4605 of the Labor Code is amended to read:

4605. Nothing contained in this chapter shall limit the right of the employee to provide, at his or her own expense, a consulting physician or any attending physicians whom he or she desires. Any report prepared by consulting or attending physicians pursuant to this section shall not be the sole basis of an award of compensation. A qualified medical evaluator or authorized treating physician shall address any report procured pursuant to this section and shall indicate whether he or she agrees or disagrees with the findings or opinions stated in the report, and shall identify the bases for this opinion.

SEC. 43. 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 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. 44. Section 4610.1 of the Labor Code is amended to read:

4610.1. An employee shall not be entitled to an increase in compensation under Section 5814 for unreasonable delay in the provision of medical treatment for periods of time necessary to complete the utilization review process in compliance with Section 4610. A determination by the appeals board or a final determination of the administrative director pursuant to independent medical review that medical treatment is appropriate shall not be conclusive evidence that medical treatment was unreasonably delayed or

denied for purposes of penalties under Section 5814. In no case shall this section preclude an employee from entitlement to an increase in compensation under Section 5814 when an employer has unreasonably delayed or denied medical treatment due to an unreasonable delay in completion of the utilization review process set forth in Section 4610.

SEC. 45. Section 4610.5 is added to the Labor Code, 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 (e) 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 plan 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. 46. Section 4610.6 is added to the Labor Code, 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. 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. 47. 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. ~~A physician already in the network may opt out from the workers' compensation medical provider network upon a 90-day written notice to an insurer, employer, or entity that provides physician network services, unless the opting out conflicts with the terms of the contract between the physician and the insurer, employer, or entity that provides physician network services.~~ 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 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. 48. Section 4616.1 of the Labor Code is amended to read:

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

(b) The administrative director shall make each approved medical provider network economic profiling policy filing available to the public upon request. The administrative director may not publicly disclose any information submitted pursuant to this section that is determined by the administrative director to be confidential pursuant to state or federal law.

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

SEC. 49. Section 4616.2 of the Labor Code is amended to read:

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

(b) If approved by the administrative director, the provisions of the written continuity of care policy shall replace all prior

continuity of care policies. The insurer, employer, or entity that provides physician network services shall file a revision of the continuity of care policy with the administrative director if it makes a material change to the policy.

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

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

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

(3) The insurer, employer, or entity that provides physician network services shall provide for the completion of treatment for the following conditions subject to coverage through the workers' compensation system:

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

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

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

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

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

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

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

(6) This section shall not require an insurer, employer, or entity that provides physician network services to provide for completion of treatment by a provider whose contract with the insurer, employer, or entity that provides physician network services has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of

subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

(7) Nothing in this section shall preclude an insurer, employer, or entity that provides physician network services from providing continuity of care beyond the requirements of this section.

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

SEC. 50. Section 4616.3 of the Labor Code is amended to read:

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

(b) The employer shall notify the employee of the existence of the medical provider network established pursuant to this article, the employee's right to change treating physicians within the network after the first visit, and the method by which the list of participating providers may be accessed by the employee. The employer's failure to provide notice as required by this subdivision or failure to post the notice as required by Section 3550 shall not be a basis for the employee to treat outside the network unless it is shown that the failure to provide notice resulted in a denial of medical care.

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

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

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

SEC. 51. Section 4616.7 of the Labor Code is amended to read:

4616.7. (a) A health care organization certified pursuant to Section 4600.5 shall be deemed approved pursuant to this article if the requirements of this article are met, as determined by the administrative director.

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

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

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

SEC. 52. Section 4620 of the Labor Code is amended to read:

4620. (a) For purposes of this article, a medical-legal expense means any costs and expenses incurred by or on behalf of any party, the administrative director, or the board, which expenses may include X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and, as needed, interpreter's fees by a certified interpreter 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, for the purpose of proving or disproving a contested claim.

(b) A contested claim exists when the employer knows or reasonably should know that the employee is claiming entitlement to any benefit arising out of a claimed industrial injury and one of the following conditions exists:

(1) The employer rejects liability for a claimed benefit.

(2) The employer fails to accept liability for benefits after the expiration of a reasonable period of time within which to decide if it will contest the claim.

(3) The employer fails to respond to a demand for payment of benefits after the expiration of any time period fixed by statute for the payment of indemnity.

(c) Costs of medical evaluations, diagnostic tests, and interpreters incidental to the production of a medical report do not constitute medical-legal expenses unless the medical report is capable of proving or disproving a disputed medical fact, the determination of which is essential to an adjudication of the employee's claim for benefits. In determining whether a report meets the requirements of this subdivision, a judge shall give full consideration to the substance as well as the form of the report, as required by applicable statutes and regulations.

(d) If the injured employee cannot effectively communicate with an examining 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 the medical examination. Upon request of the injured employee, the employer or insurance carrier ~~shallpay~~ *shall pay* the costs of the interpreter services, as set forth in the fee schedule adopted by the administrative director pursuant to Section 5811. An employer shall not be required to pay for the services of an interpreter who is provisionally certified 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.

SEC. 53. Section 4622 of the Labor Code is amended to read:

4622. All medical-legal expenses for which the employer is liable shall, upon receipt by the employer of all reports and documents required by the administrative director incident to the

services, be paid to whom the funds and expenses are due, as follows:

(a) (1) Except as provided in subdivision (b), within 60 days after receipt by the employer of each separate, written billing and report, and if payment is not made within this period, that portion of the billed sum then unreasonably unpaid shall be increased by 10 percent, together with interest thereon at the rate of 7 percent per annum retroactive to the date of receipt of the bill and report by the employer. If the employer, within the 60-day period, contests the reasonableness and necessity for incurring the fees, services, and expenses using the explanation of review required by Section 4603.3, payment shall be made within 20 days of the service of an order of the appeals board or the administrative director pursuant to Section 4603.6 directing payment.

(2) The penalty provided for in paragraph (1) shall not apply if both of the following occur:

(A) The employer pays the provider that portion of his or her charges that do not exceed the amount deemed reasonable pursuant to subdivision (e) within 60 days of receipt of the report and itemized billing.

(B) The employer prevails.

(b) (1) If the provider contests the amount paid, the provider may request a second review within 90 days of the service of the explanation of review. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and shall include all of the following:

(A) The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.

(B) The party or parties requesting the service.

(C) Any item and amount in dispute.

(D) The additional payment requested and the reason therefor.

(E) Any additional information requested in the original explanation of review and any other information provided in support of the additional payment requested.

(2) If the provider does not request a second review within 90 days, the bill will be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

(3) Within 14 days of the request for second review, the employer shall respond with a final written determination on each

of the items or amounts in dispute, including whether additional payment will be made.

(4) If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6.

(c) If the employer denies all or a portion of the amount billed for any reason other than the amount to be paid pursuant to the fee schedules in effect on the date of service, the provider may object to the denial within 90 days of the service of the explanation of review. If the provider does not object to the denial within 90 days, neither the employer nor the employee shall be liable for the amount that was denied. If the provider objects to the denial within 90 days of the service of the explanation of review, the employer shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection. If the employer prevails before the appeals board, the appeals board shall order the physician to reimburse the employer for the amount of the paid charges found to be unreasonable.

(d) If requested by the employee, or the dependents of a deceased employee, within 20 days from the filing of an order of the appeals board directing payment, and where payment is not made within that period, that portion of the billed sum then unpaid shall be increased by 10 percent, together with interest thereon at the rate of 7 percent per annum retroactive to the date of the filing of the order of the board directing payment.

(e) (1) Using the explanation of review as described in Section 4603.3, the employer shall notify the provider of the services, the employee, or if represented, his or her attorney, if the employer contests the reasonableness or necessity of incurring these expenses, and shall indicate the reasons therefor.

(2) The appeals board shall promulgate all necessary and reasonable rules and regulations to insure compliance with this section, and shall take such further steps as may be necessary to guarantee that the rules and regulations are enforced.

(3) The provisions of Sections 5800 and 5814 shall not apply to this section.

(f) Nothing contained in this section shall be construed to create a rebuttable presumption of entitlement to payment of an expense upon receipt by the employer of the required reports and

documents. This section is not applicable unless there has been compliance with Sections 4620 and 4621.

SEC. 54. Section 4650 of the Labor Code is amended to read:

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

(b) (1) If the injury causes permanent disability, the first payment shall be made within 14 days after the date of last payment of temporary disability indemnity, except as provided in paragraph (2). When the last payment of temporary disability indemnity has been made pursuant to subdivision (c) of Section 4656, and regardless of whether the extent of permanent disability can be determined at that date, the employer nevertheless shall commence the timely payment required by this subdivision and shall continue to make these payments until the employer's reasonable estimate of permanent disability indemnity due has been paid, and if the amount of permanent disability indemnity due has been determined, until that amount has been paid.

(2) Prior to an award of permanent disability indemnity, a permanent disability indemnity payment shall not be required if the employer has offered the employee a position that pays at least 85 percent of the wages and compensation paid to the employee at the time of injury or if the employee is employed in a position that pays at least 100 percent of the wages and compensation paid to the employee at the time of injury, provided that when an award of permanent disability indemnity is made, the amount then due shall be calculated from the last date for which temporary disability indemnity was paid, or the date the employee's disability became permanent and stationary, whichever is earlier.

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

(d) If any indemnity payment is not made timely as required by this section, the amount of the late payment shall be increased 10 percent and shall be paid, without application, to the employee, unless the employer continues the employee's wages under a salary continuation plan, as defined in subdivision (g). No increase shall apply to any payment due prior to or within 14 days after the date

the claim form was submitted to the employer under Section 5401. No increase shall apply when, within the 14-day period specified under subdivision (a), the employer is unable to determine whether temporary disability indemnity payments are owed and advises the employee, in the manner prescribed in rules and regulations adopted pursuant to Section 138.4, why payments cannot be made within the 14-day period, what additional information is required to make the decision whether temporary disability indemnity payments are owed, and when the employer expects to have the information required to make the decision.

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

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

(g) For purposes of this section, “salary continuation plan” means a plan that meets both of the following requirements:

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

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

SEC. 55. Section 4658 of the Labor Code is amended to read:

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

(1)

Column 1—Range of percentage of permanent disability incurred:	Column 2—Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	3
10–19.75	4
20–29.75	5
30–49.75	6
50–69.75	7
70–99.75	8

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

Column 1—Percentage of permanent disability incurred:	Column 2—Cumulative number of benefit weeks:
5	15.00

10	30.25
15	50.25
20	70.50
25	95.50
30	120.75
35	150.75
40	180.75
45	210.75
50	241.00
55	276.00
60	311.00
65	346.00
70	381.25
75	421.25
80	461.25
85	501.25
90	541.25
95	581.25
100	for life

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

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

(1)

Column 1—Range of percentage of permanent disability incurred:	Column 2—Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	3

10–19.75	4
20–24.75	5
25–29.75	6
30–49.75	7
50–69.75	8
70–99.75	9

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

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

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

Column 1—Range of percentage of permanent disability incurred:	Column 2—Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	4
10–19.75	5
20–24.75	5
25–29.75	6
30–49.75	7
50–69.75	8
70–99.75	9

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

(d) (1) This subdivision shall apply to injuries occurring on or after January 1, 2005, and as additionally provided in paragraph

(4). If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the basic disability payment computed as follows:

Column 1—Range of percentage of permanent disability incurred:	Column 2—Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
0.25–9.75.....	3
10–14.75.....	4
15–24.75.....	5
25–29.75.....	6
30–49.75.....	7
50–69.75.....	8
70–99.75.....	16

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

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

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

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

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

(e) This subdivision shall apply to injuries occurring on or after January 1, 2013. If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed as follows:

Column 1—Range of percentage of permanent disability incurred:	Column 2—Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
0.25–9.75.....	3
10–14.75.....	4
15–24.75.....	5
25–29.75.....	6
30–49.75.....	7
50–69.75.....	8
70–99.75.....	16

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

~~(B) If, within 60 days of receipt by the claims administrator of the first report received from either the primary treating physician, an agreed medical evaluator, or a qualified medical evaluator, in a form prescribed by the administrative director, finding that the disability from all conditions for which compensation is claimed has become permanent and stationary, that the injury has caused permanent partial disability, and outlining the employee's work capacities and activity restrictions, an employer does not offer the injured employee regular work, modified work, or alternative work, in the form and manner prescribed by the administrative director, for a period of at least 12 months, each disability payment remaining to be paid to the injured employee from the date of the end of the 60-day period shall be increased by 15 percent. If the employer does offer such regular work, modified work, or alternative work and the work is terminated by the employer before the end of the period for which disability payments are due to the injured employee, the amount of each of the remaining disability payments shall be increased by 15 percent. An employee who voluntarily terminates employment shall not be eligible for payment under this subparagraph. This subparagraph shall not apply to an employer that employs fewer than 50 employees.~~

(2) If the permanent disability directly caused by the industrial injury is total, payment shall be made as provided in Section 4659.

SEC. 56. Section 4658.5 of the Labor Code is amended to read:

4658.5. (a) This section shall apply to injuries occurring on or after January 1, 2004, and before January 1, 2013.

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

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

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

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

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

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

(d) A voucher issued on or after January 1, 2013, shall expire two years after the date the voucher is furnished to the employee or five years after the date of injury, whichever is later. The employee shall not be entitled to payment or reimbursement of any expenses that have not been incurred and submitted with appropriate documentation to the employer prior to the expiration date.

(e) An employer shall not be liable for compensation for injuries incurred by the employee while utilizing the voucher.

SEC. 57. Section 4658.6 of the Labor Code is amended to read:

4658.6. The employer shall not be liable for the supplemental job displacement benefit pursuant to Section 4658.5 if the employer meets either of the following conditions:

(a) Within 30 days of the termination of temporary disability indemnity payments, the employer offers, and the employee rejects, or fails to accept, in the form and manner prescribed by the administrative director, modified work, accommodating the employee's work restrictions, lasting at least 12 months.

(b) Within 30 days of the termination of temporary disability indemnity payments, the employer offers, and the employee rejects, or fails to accept, in the form and manner prescribed by the administrative director, alternative work meeting all of the following conditions:

(1) The employee has the ability to perform the essential functions of the job provided.

(2) The job provided is in a regular position lasting at least 12 months.

(3) The job provided offers wages and compensation that are within 15 percent of those paid to the employee at the time of injury.

(4) The job is located within reasonable commuting distance of the employee's residence at the time of injury.

SEC. 58. Section 4658.7 is added to the Labor Code, to read:

4658.7. (a) This section shall apply to injuries occurring on or after January 1, 2013.

(b) If the injury causes permanent partial disability, the injured employee shall be entitled to a supplemental job displacement benefit as provided in this section unless the employer makes an offer of regular, modified, or alternative work, as defined in Section 4658.1, that meets both of the following criteria:

(1) The offer is made no later than 60 days after receipt by the claims administrator of the first report received from either the primary treating physician, an agreed medical evaluator, or a qualified medical evaluator, in the form created by the administrative director pursuant to subdivision (h), finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability.

(A) If the employer or claims administrator has provided the physician with a job description of the employee's regular work, proposed modified work, or proposed alternative work, the physician shall evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description.

(B) The claims administrator shall forward the form to the employer for the purpose of fully informing the employer of work capacities and activity restrictions resulting from the injury that are relevant to potential regular, modified, or alternative work.

(2) The offer is for regular work, modified work, or alternative work lasting at least 12 months.

(c) The supplemental job displacement benefit shall be offered to the employee within 20 days after the expiration of the time for making an offer of regular, modified, or alternative work pursuant to paragraph (1) of subdivision (b).

(d) The supplemental job displacement benefit shall be in the form of a voucher redeemable as provided in this section up to an aggregate of six thousand dollars ($6,000).

(e) The voucher may be applied to any of the following expenses at the choice of the injured employee:

(1) Payment for education-related retraining or skill enhancement, or both, at a California public school or with a provider that is certified and on the state's Eligible Training Provider List (EPTL), as authorized by the federal Workforce Investment Act (P.L. 105-220), including payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement.

(2) Payment for occupational licensing or professional certification fees, related examination fees, and examination preparation course fees.

(3) Payment for the services of licensed placement agencies, vocational or return-to-work counseling, and résumé preparation, all up to a combined limit of 10 percent of the amount of the voucher.

(4) Purchase of tools required by a training or educational program in which the employee is enrolled.

(5) Purchase of computer equipment, up to one thousand dollars ($1,000).

(6) Up to five hundred dollars ($500) as a miscellaneous expense reimbursement or advance, payable upon request and without need for itemized documentation or accounting. The employee shall not be entitled to any other voucher payment for transportation, travel expenses, telephone or Internet access, clothing or uniforms, or incidental expenses.

(f) The voucher shall expire two years after the date the voucher is furnished to the employee, or five years after the date of injury, whichever is later. The employee shall not be entitled to payment or reimbursement of any expenses that have not been incurred and submitted with appropriate documentation to the employer prior to the expiration date.

(g) Settlement or commutation of a claim for the supplemental job displacement benefit shall not be permitted under Chapter 2 (commencing with Section 5000) or Chapter 3 (commencing with Section 5100) of Part 3.

(h) The administrative director shall adopt regulations for the administration of this section, including, but not limited to, both of the following:

(1) The time, manner, and content of notices of rights under this section.

(2) The form of a mandatory attachment to a medical report to be forwarded to the employer pursuant to paragraph (1) of subdivision (b) for the purpose of fully informing the employer of work capacities and of activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work.

(i) An employer shall not be liable for compensation for injuries incurred by the employee while utilizing the voucher.

SEC. 59. Section 4660 of the Labor Code is amended to read:

4660. This section shall only apply to injuries occurring before January 1, 2013.

(a) In determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury, consideration being given to an employee's diminished future earning capacity.

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

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

(c) The administrative director shall amend the schedule for the determination of the percentage of permanent disability in accordance with this section at least once every five years. This schedule shall be available for public inspection and, without formal introduction in evidence, shall be prima facie evidence of

the percentage of permanent disability to be attributed to each injury covered by the schedule.

(d) The schedule shall promote consistency, uniformity, and objectivity. The schedule and any amendment thereto or revision thereof shall apply prospectively and shall apply to and govern only those permanent disabilities 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 fact may be. For compensable claims arising before January 1, 2005, the schedule as revised pursuant to changes made in legislation enacted during the 2003–04 Regular and Extraordinary Sessions shall apply to the determination of permanent disabilities when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by Section 4061 to the injured worker.

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

SEC. 60. Section 4660.1 is added to the Labor Code, 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 shall be no increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, 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, 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.

SEC. 61. Section 4701 of the Labor Code is amended to read:

4701. If an injury causes death, either with or without disability, the employer shall be liable, in addition to any other benefits provided by this division, for all of the following:

(a) Reasonable expenses of the employee's burial, in accordance with the following:

(1) Up to two thousand dollars ($2,000) for injuries occurring prior to January 1, 1991.

(2) Up to five thousand dollars ($5,000) for injuries occurring on or after January 1, 1991, and prior to January 1, 2013.

(3) Up to ten thousand dollars ($10,000) for injuries occurring on or after January 1, 2013.

(b) A death benefit, to be allowed to the dependents when the employee leaves any person dependent upon him or her for support.

SEC. 62. Section 4903 of the Labor Code is amended to read:

4903. The appeals board may determine, and allow as liens against any sum to be paid as compensation, any amount determined as hereinafter set forth in subdivisions (a) through (i). If more than one lien is allowed, the appeals board may determine the priorities, if any, between the liens allowed. The liens that may be allowed hereunder are as follows:

(a) A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. No fee for legal services shall be awarded to any representative who is not an attorney, except with respect to those claims for compensation for which an application, pursuant to Section 5501, has been filed with the appeals board on or before December 31, 1991, or for which a disclosure form, pursuant to Section 4906, has been sent to the employer, or insurer or third-party administrator, if either is known, on or before December 31, 1991.

(b) The reasonable expense incurred by or on behalf of the injured employee, as provided by Article 2 (commencing with Section 4600), except those disputes subject to independent medical review or independent bill review.

(c) The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury.

(d) The reasonable burial expenses of the deceased employee, not to exceed the amount provided for by Section 4701.

(e) The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. These expenses shall be allowed in the proportion that the appeals board deems proper, under application of the spouse, guardian of the minor children, or the assignee, pursuant to subdivision (a) of Section 11477 of the Welfare and Institutions Code, of the spouse, a former spouse, or minor children. A collection received as a result of a lien against a workers' compensation award imposed pursuant to this subdivision for payment of child support ordered by a court shall be credited as provided in Section 695.221 of the Code of Civil Procedure.

(f) The amount of unemployment compensation disability benefits that have been paid under or pursuant to the Unemployment Insurance Code in those cases where, pending a determination under this division there was uncertainty whether the benefits were payable under the Unemployment Insurance Code or payable hereunder; provided, however, that any lien under this subdivision shall be allowed and paid as provided in Section 4904.

(g) The amount of unemployment compensation benefits and extended duration benefits paid to the injured employee for the same day or days for which he or she receives, or is entitled to receive, temporary total disability indemnity payments under this division; provided, however, that any lien under this subdivision shall be allowed and paid as provided in Section 4904.

(h) The amount of family temporary disability insurance benefits that have been paid to the injured employee pursuant to the Unemployment Insurance Code for the same day or days for which that employee receives, or is entitled to receive, temporary total disability indemnity payments under this division, provided, however, that any lien under this subdivision shall be allowed and paid as provided in Section 4904.

(i) The amount of indemnification granted by the California Victims of Crime Program pursuant to Article 1 (commencing

with Section 13959) of Chapter 5 of Part 4 of Division 3 of Title 2 of the Government Code.

SEC. 63. Section 4903.05 is added to the Labor Code, to read:

4903.05. (a) Every lien claimant shall file its lien with the appeals board in writing upon a form approved by the appeals board. The lien shall be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement and proof of service upon the injured worker or, if deceased, upon the worker's dependents, the employer, the insurer, and the respective attorneys or other agents of record. Medical records shall be filed only if they are relevant to the issues being raised by the lien.

(b) Any lien claim for expenses under subdivision (b) of Section 4903 or for claims of costs shall be filed with the appeals board electronically using the form approved by the appeals board. The lien shall be accompanied by a proof of service and any other documents that may be required by the appeals board. The service requirements for Section 4603.2 are not modified by this section.

(c) All liens filed on or after January 1, 2013, for expenses under subdivision (b) of Section 4903 or for claims of costs shall be subject to a filing fee as provided by this subdivision.

(1) The lien claimant shall pay a filing fee of one hundred fifty dollars ($150) to the Division of Workers' Compensation prior to filing a lien and shall include proof that the filing fee has been paid. The fee shall be collected through an electronic payment system that accepts major credit cards and any additional forms of electronic payment selected by the administrative director. If the administrative director contracts with a service provider for the processing of electronic payments, any processing fee shall be absorbed by the division and not added to the fee charged to the lien filer.

(2) On or after January 1, 2013, a lien submitted for filing that does not comply with paragraph (1) shall be invalid, even if lodged with the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

(3) The claims of two or more providers of goods or services shall not be merged into a single lien.

(4) The filing fee shall be collected by the administrative director. All fees shall be deposited in the Workers' Compensation

Administration Revolving Fund and applied for the purposes of that fund.

(5) The administrative director shall adopt reasonable rules and regulations governing the procedure for the collection of the filing fee, including emergency regulations as necessary to implement this section.

(6) Any lien filed for goods or services that are not the proper subject of a lien may be dismissed upon request of a party by verified petition or on the appeals board's own motion. If the lien is dismissed, the lien claimant will not be entitled to reimbursement of the filing fee.

(7) No filing fee shall be required for a lien filed by a health care service plan licensed pursuant to Section 1349 of the Health and Safety Code, a group disability insurer under a policy issued in this state pursuant to the provisions of Section 10270.5 of the Insurance Code, a self-insured employee welfare benefit plan, as defined in Section 10121 of the Insurance Code, that is issued in this state, a Taft-Hartley health and welfare fund, or a publicly funded program providing medical benefits on a nonindustrial basis.

SEC. 64. Section 4903.06 is added to the Labor Code, to read:

4903.06. (a) Any lien filed pursuant to subdivision (b) of Section 4903 prior to January 1, 2013, and any cost that was filed as a lien prior to January 1, 2013, shall be subject to a lien activation fee unless the lien claimant provides proof of having paid a filing fee as previously required by former Section 4903.05 as added by Chapter 639 of the Statutes of 2003.

(1) The lien claimant shall pay a lien activation fee of one hundred dollars ($100) to the Division of Workers' Compensation on or before January 1, 2014. The fee shall be collected through an electronic payment system that accepts major credit cards and any additional forms of electronic payment selected by the administrative director. If the administrative director contracts with a service provider for the processing of electronic payments, any processing fee shall be absorbed by the division and not added to the fee charged to the lien filer.

(2) The lien claimant shall include proof of payment of the filing fee or lien activation fee with the declaration of readiness to proceed.

(3) The lien activation fee shall be collected by the administrative director. All fees shall be deposited in the Workers' Compensation Administration Revolving Fund and applied for the purposes of that fund. The administrative director shall adopt reasonable rules and regulations governing the procedure for the collection of the lien activation fee and to implement this section, including emergency regulations, as necessary.

(4) All lien claimants that did not file the declaration of readiness to proceed and that remain a lien claimant of record at the time of a lien conference shall submit proof of payment of the activation fee at the lien conference. If the fee has not been paid or no proof of payment is available, the lien shall be dismissed with prejudice.

(5) Any lien filed pursuant to subdivision (b) of Section 4903 prior to January 1, 2013, and any cost that was filed as a lien prior to January 1, 2013, for which the filing fee or lien activation fee has not been paid by January 1, 2014, is dismissed by operation of law.

(b) This section shall not apply to any lien filed by a health care service plan licensed pursuant to Section 1349 of the Health and Safety Code, a group disability insurer under a policy issued in this state pursuant to the provisions of Section 10270.5 of the Insurance Code, a self-insured employee welfare benefit plan, as defined in Section 10121 of the Insurance Code, that is issued in this state, a Taft-Hartley health and welfare fund, or a publicly funded program providing medical benefits on a nonindustrial basis.

SEC. 65. Section 4903.07 is added to the Labor Code, to read:

4903.07. (a) A lien claimant shall be entitled to an order or award for reimbursement of a lien filing fee or lien activation fee, together with interest at the rate allowed on civil judgments, only if all of the following conditions are satisfied:

(1) Not less than 30 days before filing the lien for which the filing fee was paid or filing the declaration of readiness for which the lien activation fee was paid, the lien claimant has made written demand for settlement of the lien claim for a clearly stated sum which shall be inclusive of all claims of debt, interest, penalty, or other claims potentially recoverable on the lien.

(2) The defendant fails to accept the settlement demand in writing within 20 days of receipt of the demand for settlement, or

within any additional time as may be provide by the written demand.

(3) After submission of the lien dispute to the appeals board or an arbitrator, a final award is made in favor of the lien claimant of a specified sum that is equal to or greater than the amount of the settlement demand. The amount of the interest and filing fee or lien activation fee shall not be considered in determining whether the award is equal to or greater than the demand.

(b) This section shall not preclude an order or award of reimbursement of the filing fee or activation fee pursuant to the express terms of an agreed disposition of a lien dispute.

SEC. 66. Section 4903.1 of the Labor Code is amended to read:

4903.1. (a) The appeals board or arbitrator, before issuing an award or approval of any compromise of claim, shall determine, on the basis of liens filed with it pursuant to Section 4903.05, whether any benefits have been paid or services provided by a health care provider, a health care service plan, a group disability policy, including a loss of income policy or a self-insured employee welfare benefit plan, and its award or approval shall provide for reimbursement for benefits paid or services provided under these plans as follows:

(1) If the appeals board issues an award finding that an injury or illness arises out of and in the course of employment, but denies the applicant reimbursement for self-procured medical costs solely because of lack of notice to the applicant's employer of his need for hospital, surgical, or medical care, the appeals board shall nevertheless award a lien against the employee's recovery, to the extent of benefits paid or services provided, for the effects of the industrial injury or illness, by a health care provider, a health care service plan, a group disability policy or a self-insured employee welfare benefit plan, subject to the provisions described in subdivision (b).

(2) If the appeals board issues an award finding that an injury or illness arises out of and in the course of employment, and makes an award for reimbursement for self-procured medical costs, the appeals board shall allow a lien, to the extent of benefits paid or services provided, for the effects of the industrial injury or illness, by a health care provider, a health care service plan, a group disability policy or a self-insured employee welfare benefit plan, subject to the provisions of subdivision (b). For purposes of this

paragraph, benefits paid or services provided by a self-insured employee welfare benefit plan shall be determined notwithstanding the official medical fee schedule adopted pursuant to Section 5307.1.

(3) If the appeals board issues an award finding that an injury or illness arises out of and in the course of employment and makes an award for temporary disability indemnity, the appeals board shall allow a lien as living expense under Section 4903, for benefits paid by a group disability policy providing loss of time benefits. The lien shall be allowed to the extent that benefits have been paid for the same day or days for which temporary disability indemnity is awarded and shall not exceed the award for temporary disability indemnity. A lien shall not be allowed hereunder unless the group disability policy provides for reduction, exclusion, or coordination of loss of time benefits on account of workers' compensation benefits.

(4) If the parties propose that the case be disposed of by way of a compromise and release agreement, in the event the lien claimant, other than a health care provider, does not agree to the amount allocated to it, then the appeals board shall determine the potential recovery and reduce the amount of the lien in the ratio of the applicant's recovery to the potential recovery in full satisfaction of its lien claim.

(b) Notwithstanding subdivision (a), payment or reimbursement shall not be allowed, whether payable by the employer or payable as a lien against the employee's recovery, for any expense incurred as provided by Article 2 (commencing with Section 4600) of Chapter 2 of Part 2, nor shall the employee have any liability for the expense, if at the time the expense was incurred the provider either knew or in the exercise of reasonable diligence should have known that the condition being treated was caused by the employee's present or prior employment, unless at the time the expense was incurred at least one of the following conditions was met:

(1) The expense was incurred for services authorized by the employer.

(2) The expense was incurred for services furnished while the employer failed or refused to furnish treatment as required by subdivision (c) of Section 5402.

(3) The expense was necessarily incurred for an emergency medical condition, as defined by subdivision (b) of Section 1317.1 of the Health and Safety Code.

(c) The changes made to this section by Senate Bill 457 of the 2011–12 Regular Session do not modify in any way the rights or obligations of the following:

(1) Any health care provider to file and prosecute a lien pursuant to subdivision (b) of Section 4903.

(2) A payer to conduct utilization review pursuant to Section 4610.

(3) Any party in complying with the requirements under Section 4903.

SEC. 66.5. Section 4903.1 of the Labor Code is amended to read:

4903.1. (a) The appeals board~~,~~ *or* arbitrator,~~ or settlement conference referee,~~ before issuing an award or approval of any compromise of claim, shall determine, on the basis of liens filed with it pursuant to~~ subdivision (b) or (c)~~ *Section 4903.05*, whether any benefits have been paid or services provided by a health care provider, a health care service plan, a group disability policy, including a~~ loss of income~~ *loss-of-income* policy~~,~~ *or* a self-insured employee welfare benefit plan,~~ or a hospital service contract,~~ and its award or approval shall provide for reimbursement for benefits paid or services provided under these plans as follows:

(1) ~~When the referee~~ *If the appeals board* issues an award finding that an injury or illness arises out of and in the course of employment, but denies the applicant reimbursement for self-procured medical costs solely because of lack of notice to the applicant's employer of his *or her* need for hospital, surgical, or medical care, the appeals board shall nevertheless award a lien against the employee's recovery, to the extent of benefits paid or services provided, for the effects of the industrial injury or illness, by a health care provider, a health care service plan, a group disability policy~~,~~ *or* a self-insured employee welfare benefit plan, ~~or a hospital service contract~~ *subject to the provisions described in subdivision (b)*.

(2) ~~When the referee~~ *If the appeals board* issues an award finding that an injury or illness arises out of and in the course of employment, and makes an award for reimbursement for self-procured medical costs, the appeals board shall allow a lien,

to the extent of benefits paid or services provided, for the effects of the industrial injury or illness, by a health care provider, a health care service plan, a group disability policy~~,~~ *or* a self-insured employee welfare benefit plan~~, or a hospital service contract~~ *subject to the provisions of subdivision (b)*. For purposes of this paragraph, benefits paid or services provided by a self-insured employee welfare benefit plan shall be determined notwithstanding the official medical fee schedule adopted pursuant to Section 5307.1.

~~(3) When the referee~~

(3) (A) If the appeals board issues an award finding that an injury or illness arises out of and in the course of employment and makes an award for temporary disability indemnity, the appeals board shall allow a lien as living expense under Section 4903, for benefits paid by a group disability policy providing ~~loss of time benefits. Such~~ *loss-of-time benefits and for loss-of-time benefits paid by a self-insured employee welfare benefit plan. The* lien shall be allowed to the extent that benefits have been paid for the same day or days for which temporary disability indemnity is awarded and shall not exceed the award for temporary disability indemnity. ~~No lien shall~~ *A lien shall not* be allowed hereunder unless the group disability policy *or self-insured employee welfare benefit plan* provides for reduction, exclusion, or coordination of ~~loss of time~~ *loss-of-time* benefits on account of workers' compensation benefits.

(B) For purposes of this paragraph, "self-insured employee welfare benefit plan" means any plan, fund, or program that is established or maintained by an employer or by an employee organization, or by both, to the extent that the plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, other than through the purchase of insurance, either of the following:

(i) Medical, surgical, or hospital care or benefits.

(ii) Monetary or other benefits in the event of sickness, accident, disability, death, or unemployment.

(4) ~~When~~ *If* the parties propose that the case be disposed of by way of a compromise and release agreement, in the event the lien claimant, other than a health care provider, does not agree to the amount allocated to it, then the ~~referee~~ *appeals board* shall determine the potential recovery and reduce the amount of the lien in the ratio of the applicant's recovery to the potential recovery in full satisfaction of its lien claim.

~~(b) When a compromise of claim or an award is submitted to the appeals board, arbitrator, or settlement conference referee for approval, the parties shall file with the appeals board, arbitrator, or settlement conference referee any liens served on the parties.~~

~~(c) Any lien claimant under Section 4903 or this section shall file its lien with the appeals board in writing upon a form approved by the appeals board. The lien shall be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement and proof of service upon the injured worker, or if deceased, upon the worker's dependents, the employer, the insurer, and the respective attorneys or other agents of record.~~

~~(d) The appeals board shall file liens required by subdivision (c) immediately upon receipt. Numbers shall be assigned pursuant to subdivision (c) of Section 5500.~~

(b) Notwithstanding subdivision (a), payment or reimbursement shall not be allowed, whether payable by the employer or payable as a lien against the employee's recovery, for any expense incurred as provided by Article 2 (commencing with Section 4600) of Chapter 2 of Part 2, nor shall the employee have any liability for the expense, if at the time the expense was incurred the provider either knew or in the exercise of reasonable diligence should have known that the condition being treated was caused by the employee's present or prior employment, unless at the time the expense was incurred at least one of the following conditions was met:

(1) The expense was incurred for services authorized by the employer.

(2) The expense was incurred for services furnished while the employer failed or refused to furnish treatment as required by subdivision (e) of Section 5402.

(3) The expense was necessarily incurred for an emergency medical condition, as defined by subdivision (c) of Section 1317.1 of the Health and Safety Code.

~~(e)~~

(c) The changes made to this section by Senate Bill 457 of the 2011–12 Regular Session do not modify in any way the rights or obligations of the following:

(1) Any health care provider to file and prosecute a lien pursuant to subdivision (b) of Section 4903.

(2) A ~~payor~~ *payer* to conduct utilization review pursuant to Section 4610.

(3) Any party in complying with the requirements under Section 4903.

SEC. 67. 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.

SEC. 68. Section 4903.5 of the Labor Code is amended to read:

4903.5. (a) A lien claim for expenses as provided in subdivision (b) of Section 4903 shall not be filed after three years from the date the services were provided, nor more than 18 months after the date the services were provided, if the services were provided on or after July 1, 2013.

(b) Notwithstanding subdivision (a), any health care service plan licensed pursuant to Section 1349 of the Health and Safety Code, group disability insurer under a policy issued in this state pursuant to the provisions of Section 10270.5 of the Insurance Code, self-insured employee welfare benefit plan issued in this state as defined in Section 10121 of the Insurance Code, Taft-Hartley health and welfare fund, or publicly funded program providing medical benefits on a nonindustrial basis, may file a lien claim for expenses as provided in subdivision (b) of Section 4903 within 12 months after the entity first knew or in the exercise of reasonable diligence should have known that an industrial injury is being claimed, but in no event later than five years from the date the services were provided to the employee.

(c) The injured worker shall not be liable for any underlying obligation if a lien claim has not been filed and served within the allowable period. Except when the lien claimant is the applicant

as provided in Section 5501 or as otherwise permitted by rules of practice and procedure adopted by the appeals board, a lien claimant shall not file a declaration of readiness to proceed in any case until the case-in-chief has been resolved.

(d) This section shall not apply to civil actions brought under the Cartwright Act (Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code), the Unfair Practices Act (Chapter 4 (commencing with Section 17000) of Part 2 of Division 7 of the Business and Professions Code), or the federal Racketeer Influenced and Corrupt Organization Act (Chapter 96 (commencing with Section 1961) of Title 18 of the United States Code) based on concerted action with other insurers that are not parties to the case in which the lien or claim is filed.

SEC. 69. 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, no lien claimant shall be entitled to any medical information, as defined in subdivision (g) of Section 50.05 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 such 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.

SEC. 70. Section 4903.8 is added to the Labor Code, to read:

4903.8. (a) Any order or award for payment of a lien filed pursuant to subdivision (b) of Section 4903 shall be made for payment only to the person who was entitled to payment for the expenses as provided in subdivision (b) of Section 4903 at the time the expenses were incurred, and not to an assignee unless the person has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interests in the remaining accounts receivable to the assignee.

(b) If there has been an assignment of a lien, either as an assignment of all right, title, and interest in the accounts receivable or as an assignment for collection, a true and correct copy of the assignment shall be filed and served.

(1) If the lien is filed on or after January 1, 2013, and the assignment occurs before the filing of the lien, the copy of the assignment shall be served at the time the lien is filed.

(2) If the lien is filed on or after January 1, 2013, and the assignment occurs after the filing of the lien, the copy of the assignment shall be served within 20 days of the date of the assignment.

(3) If the lien is filed before January 1, 2013, the copy of the assignment shall be served by January 1, 2014, or with the filing of a declaration of readiness or at the time of a lien hearing, whichever is earliest.

(c) If there has been more than one assignment of the same receivable or bill, the appeals board may set the matter for hearing on whether the multiple assignments constitute bad-faith actions or tactics that are frivolous, harassing, or intended to cause unnecessary delay or expense. If so found by the appeals board, appropriate sanctions, including costs and attorney's fees, may be awarded against the assignor, assignee, and their respective attorneys.

(d) At the time of filing of a lien on or after January 1, 2013, or in the case of a lien filed before January 1, 2013, at the earliest of the filing of a declaration of readiness, a lien hearing, or January 1, 2014, supporting documentation shall be filed including one or more declarations under penalty of perjury by a natural person or persons competent to testify to the facts stated, declaring both of the following:

(1) The services or products described in the bill for services or products were actually provided to the injured employee.

(2) The billing statement attached to the lien truly and accurately describes the services or products that were provided to the injured employee.

(e) A lien submitted for filing on or after January 1, 2013, for expenses provided in subdivision (b) of Section 4903, that does not comply with the requirements of this section shall be deemed to be invalid, whether or not accepted for filing by the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

(f) This section shall take effect without regulatory action. The appeals board and the administrative director may promulgate regulations and forms for the implementation of this section.

SEC. 71. Section 4904 of the Labor Code is amended to read:

4904. (a) If notice is given in writing to the insurer, or to the employer if uninsured, setting forth the nature and extent of any

claim that is allowable as a lien in favor of the Employment Development Department, the claim is a lien against any amount thereafter payable as temporary or permanent disability compensation, subject to the determination of the amount and approval of the lien by the appeals board. When the Employment Development Department has served an insurer or employer with a lien claim, the insurer or employer shall notify the Employment Development Department, in writing, as soon as possible, but in no event later than 15 working days after commencing disability indemnity payments. When a lien has been served on an insurer or an employer by the Employment Development Department, the insurer or employer shall notify the Employment Development Department, in writing, within 10 working days of filing an application for adjudication, a stipulated award, or a compromise and release with the appeals board.

(b) (1) In determining the amount of lien to be allowed for unemployment compensation disability benefits under subdivision (f) of Section 4903, the appeals board shall allow the lien in the amount of benefits which it finds were paid for the same day or days of disability for which an award of compensation for any permanent disability indemnity resulting solely from the same injury or illness or temporary disability indemnity, or both, is made and for which the employer has not reimbursed the Employment Development Department pursuant to Section 2629.1 of the Unemployment Insurance Code.

(2) In determining the amount of lien to be allowed for unemployment compensation benefits and extended duration benefits under subdivision (g) of Section 4903, the appeals board shall allow the lien in the amount of benefits which it finds were paid for the same day or days for which an award of compensation for temporary total disability is made.

(3) In determining the amount of lien to be allowed for family temporary disability insurance benefits under subdivision (h) of Section 4903, the appeals board shall allow the lien in the amount of benefits that it finds were paid for the same day or days for which an award of compensation for temporary total disability is made and for which the employer has not reimbursed the Employment Development Department pursuant to Section 2629.1 of the Unemployment Insurance Code.

(c) In the case of agreements for the compromise and release of a disputed claim for compensation, the applicant and defendant may propose to the appeals board, as part of the compromise and release agreement, an amount out of the settlement to be paid to any lien claimant claiming under subdivision (f), (g), or (h) of Section 4903. If the lien claimant objects to the amount proposed for payment of its lien under a compromise and release settlement or stipulation, the appeals board shall determine the extent of the lien claimant's entitlement to reimbursement on its lien and make and file findings on all facts involved in the controversy over this issue in accordance with Section 5313. The appeals board may approve a compromise and release agreement or stipulation which proposes the disallowance of a lien, in whole or in part, only where there is proof of service upon the lien claimant by the defendant, not less than 15 days prior to the appeals board action, of all medical and rehabilitation documents and a copy of the proposed compromise and release agreement or stipulation. The determination of the appeals board, subject to petition for reconsideration and to the right of judicial review, as to the amount of lien allowed under subdivision (f), (g), or (h) of Section 4903, whether in connection with an award of compensation or the approval of a compromise and release agreement, shall be binding on the lien claimant, the applicant, and the defendant, insofar as the right to benefits paid under the Unemployment Insurance Code for which the lien was claimed. The appeals board may order the amount of any lien claim, as determined and allowed by it, to be paid directly to the person entitled, either in a lump sum or in installments.

(d) Where unemployment compensation disability benefits, including family temporary disability insurance benefits, have been paid pursuant to the Unemployment Insurance Code while reconsideration of an order, decision, or award is pending, or has been granted, the appeals board shall determine and allow a final amount on the lien as of the date the board is ready to issue its decision denying a petition for reconsideration or affirming, rescinding, altering or amending the original findings, order, decision, or award.

(e) The appeals board shall not be prohibited from approving a compromise and release agreement on all other issues and deferring to subsequent proceedings the determination of a lien claimant's

entitlement to reimbursement if the defendant in any of these proceedings agrees to pay the amount subsequently determined to be due under the lien claim.

(f) The amendments made to this section by the act adding this subdivision are declaratory of existing law, and shall not constitute good cause to reopen, rescind, or amend any final order, decision, or award of the appeals board.

SEC. 72. Section 4905 of the Labor Code is amended to read:

4905. Except with regard to liens as permitted by subdivision (b) of Section 4903, if it appears in any proceeding pending before the appeals board that a lien should be allowed if it had been duly requested by the party entitled thereto, the appeals board may, without any request for such lien having been made, order the payment of the claim to be made directly to the person entitled, in the same manner and with the same effect as though the lien had been regularly requested, and the award to such person shall constitute a lien against unpaid compensation due at the time of service of the award.

SEC. 73. Section 4907 of the Labor Code is amended to read:

4907. (a) The privilege of any person, except attorneys admitted to practice in the Supreme Court of the state, to appear in any proceeding as a representative of any party before the appeals board, or any of its workers' compensation administrative law judges, may, after a hearing, be removed, denied, or suspended by the appeals board for either of the following:

(1) For a violation of this chapter, the Rules of the Workers' Compensation Appeals Board, or the Rules of the Administrative Director.

(2) For other good cause, including, but not limited to, failure to pay final order of sanctions, attorney's fees, or costs issued under Section 5813.

(b) For purposes of this section, nonattorney representatives shall be held to the same professional standards of conduct as attorneys.

SEC. 74. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) (1) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and

all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (j), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(2) (A) The administrative director, after public hearings, shall adopt and review periodically an official medical fee schedule based on the resource-based relative value scale for physician services and nonphysician practitioner services, as defined by the administrative director, provided that all of the following apply:

(i) Employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600.

~~(ii) The maximum allowable fees incorporate a statewide geographic adjustment factor of 1.078.~~

~~(iii)~~

(ii) The fee schedule is updated annually to reflect changes in procedure codes, relative weights, and the adjustment factor provided in subdivision (g).

~~(iv)~~

(iii) The maximum reasonable fees paid shall not exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services as it appeared on July 1, 2012, before application of the adjustment factor provided in subdivision (g). *For purposes of calculating maximum reasonable fees, any service provided to injured workers that is not covered under the federal Medicare program shall be included at its rate of payment established by the administrative director pursuant to subdivision (d).*

~~(v)~~

(iv) There shall be a four-year transition between the estimated aggregate maximum allowable amount under the official medical fee schedule for physician services prior to January 1, 2014, and the maximum allowable amount based on the resource-based relative value scale at 120 percent of the Medicare conversion factors as adjusted pursuant to this section.

(B) The ~~administrative director shall adopt billing rules that differ from Medicare billing rules to the extent that the administrative director determines that the differences are appropriate to meet the needs of the workers' compensation system.~~ *official medical fee schedule shall include payment ground rules that differ from Medicare payment ground rules, including, as appropriate, payment of consultation codes and payment evaluation and management services provided during a global period of surgery.*

(C) Commencing January 1, 2014, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the resource-based relative value scale, the maximum reasonable fees for physician services and nonphysician practitioner services, including, but not limited to, physician assistant, nurse practitioner, and physical therapist services, shall be in accordance with the fee-related structure and rules of the Medicare payment system for physician services and nonphysician practitioner services, ~~including Medicare's geographic adjustment factor~~ *except that an average statewide geographic adjustment factor of 1.078 shall apply in lieu of*

Medicare's locality-specific geographic adjustment factors, and shall incorporate the following conversion factors:

(i) For dates of service in 2014, forty-nine dollars and five thousand three hundred thirteen ten thousandths cents ($49.5313) for surgery, fifty-six dollars and two thousand three hundred twenty-nine ten thousandths cents ($56.2329) for radiology, thirty dollars and six hundred forty-seven ten thousandths cents ($30.0647) for anesthesia, and thirty-seven dollars and one thousand seven hundred twelve ten thousandths cents ($37.1712) for all other before application of the adjustment factor provided in subdivision (g).

(ii) For dates of service in 2015, forty-six dollars and six thousand three hundred fifty-nine ten thousandths cents ($46.6359) for surgery, fifty-one dollars and one thousand thirty-six ten thousandths cents ($51.1036) for radiology, twenty-eight dollars and six thousand sixty-seven ten thousandths cents ($28.6067) for anesthesia, and thirty-eight dollars and three thousand nine hundred fifty-eight ten thousandths cents ($38.3958) for all other before application of the adjustment factor provided in subdivision (g).

(iii) For dates of service in 2016, forty-three dollars and seven thousand four hundred five ten thousandths cents ($43.7405) for surgery, forty-five dollars and nine thousand seven hundred forty-four ten thousandths cents ($45.9744) for radiology, twenty-seven dollars and one thousand four hundred eighty-seven thousandths cents ($27.1487) for anesthesia, and thirty-nine dollars and six thousand two hundred five ten thousandths cents ($39.6205) for all other before application of the adjustment factor provided in subdivision (g).

(iv) For dates of service on or after January 1, 2017, 120 percent of the 2012 Medicare conversion factor as updated pursuant to subdivision (g).

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic-related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) *(1)* Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in a hospital outpatient

department, shall not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department, and the maximum facility fee for services performed in an ambulatory surgical center shall not exceed 80 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(2) The department shall study the feasibility of establishing a facility fee for services that are performed in an ambulatory surgical center and are not subject to a fee paid by Medicare for services performed in an outpatient department, set at 85 percent of the diagnostic-related group (DRG) fee paid by Medicare for the same services performed in a hospital inpatient department. The department shall report the finding to the Senate Labor Committee and Assembly Insurance Committee no later than July 1, 2013.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item. However, the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) (1) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003, except as otherwise provided in this subdivision.

(2) Any compounded drug product shall be billed by the compounding pharmacy or dispensing physician at the ingredient level, with each ingredient identified using the applicable National Drug Code (NDC) of the ingredient and the corresponding quantity, and in accordance with regulations adopted by the California State Board of Pharmacy. Ingredients with no NDC shall not be separately reimbursable. The ingredient-level reimbursement shall

be equal to 100 percent of the reimbursement allowed by the Medi-Cal payment system and payment shall be based on the sum of the allowable fee for each ingredient plus a dispensing fee equal to the dispensing fee allowed by the Medi-Cal payment systems. If the compounded drug product is dispensed by a physician, the maximum reimbursement shall not exceed 300 percent of documented paid costs, but in no case more than twenty dollars ($20) above documented paid costs.

(3) For a dangerous drug dispensed by a physician that is a finished drug product approved by the federal Food and Drug Administration, the maximum reimbursement shall be according to the official medical fee schedule adopted by the administrative director.

(4) For a dangerous device dispensed by a physician, the reimbursement to the physician shall not exceed either of the following:

(A) The amount allowed for the device pursuant to the official medical fee schedule adopted by the administrative director.

(B) One hundred twenty percent of the documented paid cost, but not less than 100 percent of the documented paid cost plus the minimum dispensing fee allowed for dispensing prescription drugs pursuant to the official medical fee schedule adopted by the administrative director, and not more than 100 percent of the documented paid cost plus two hundred fifty dollars ($250).

(5) For any pharmacy goods dispensed by a physician not subject to paragraph (2), (3), or (4), the maximum reimbursement to a physician for pharmacy goods dispensed by the physician shall not exceed any of the following:

(A) The amount allowed for the pharmacy goods pursuant to the official medical fee schedule adopted by the administrative director or pursuant to paragraph (2), as applicable.

(B) One hundred twenty percent of the documented paid cost to the physician.

(C) One hundred percent of the documented paid cost to the physician plus two hundred fifty dollars ($250).

(6) For the purposes of this subdivision, the following definitions apply:

(A) “Administer” or “administered” has the meaning defined by Section 4016 of the Business and Professions Code.

(B) "Compounded drug product" means any drug product subject to Article 4.5 (commencing with Section 1735) of Division 17 of Title 16 of the California Code of Regulations or other regulation adopted by the State Board of Pharmacy to govern the practice of compounding.

(C) "Dispensed" means furnished to or for a patient as contemplated by Section 4024 of the Business and Professions Code and does not include "administered."

(D) "Dangerous drug" and "dangerous device" have the meanings defined by Section 4022 of the Business and Professions Code.

(E) "Documented paid cost" means the unit price paid for the specific product or for each component used in the product as documented by invoices, proof of payment, and inventory records as applicable, or as documented in accordance with regulations that may be adopted by the administrative director, net of rebates, discounts, and any other immediate or anticipated cost adjustments.

(F) "Pharmacy goods" has the same meaning as set forth in Section 139.3.

(7) To the extent that any provision of paragraphs (2) to (6), inclusive, is inconsistent with any provision of the official medical fee schedule adopted by the administrative director on or after January 1, 2012, the provision adopted by the administrative director shall govern.

(8) Notwithstanding paragraph (7), the provisions of this subdivision concerning physician-dispensed pharmacy goods shall not be superseded by any provision of the official medical fee schedule adopted by the administrative director unless the relevant official medical fee schedule provision is expressly applicable to physician-dispensed pharmacy goods.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, subject to the following provisions:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital

outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(iii) The annual adjustment factor for physician services shall be based on the product of one plus the percentage change in the Medicare Economic Index and any relative value scale adjustment factor.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003, and the adjustment factor in clause (iii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2012.

(C) The maximum reasonable fees paid for pharmacy services and drugs shall not include any reductions in the relevant Medi-Cal payment system implemented pursuant to Section 14105.192 of the Welfare and Institutions Code.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the Division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) "Medicare Economic Index" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) "Hospital market basket" means the input price index used by the federal Centers for Medicare and Medicaid Services to

measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) "Hospital market basket for excluded hospitals" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(D) "Relative value scale adjustment factor" means the annual factor applied by the federal Centers for Medicare and Medicaid Services to the Medicare conversion factor to make changes in relative value units for the physician fee schedule budget neutral.

(h) This section does not prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components shall not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Except as revised by the administrative director, the official medical fee schedule rates for physician services in effect on December 31, 2012, shall remain in effect until January 1, 2014.

(*l*) Notwithstanding subdivision (a), any explicit reductions in the Medi-Cal fee schedule for pharmacy services and drugs to meet the budgetary targets provided in Section 14105.192 of the Welfare and Institutions Code shall not be reflected in the official medical fee schedule.

(m) On or before July 1, 2013, the administrative director shall adopt a regulation specifying an additional reimbursement for MS-DRGs Medicare Severity Diagnostic Related Groups (MS-DRGs) 028, 029, 030, 453, 454, 455, and 456 to ensure that the aggregate reimbursement is sufficient to cover costs, including

the implantable medical device, hardware, and instrumentation. This regulation shall be repealed as of January 1, 2014, unless extended by the administrative director.

SEC. 75. Section 5307.7 of the Labor Code is amended to read:

5307.7. (a) On or before January 1, 2013, the administrative director shall adopt, after public hearings, a fee schedule that shall establish reasonable fees paid for services provided by vocational experts, including, but not limited to, vocational evaluations and expert testimony determined to be reasonable, actual, and necessary by the appeals board.

(b) A vocational expert shall not be paid, and the appeals board shall not allow, vocational expert fees in excess of those that are reasonable, actual, and necessary, or that are not consistent with the fee schedule adopted by the administrative director.

SEC. 76. Section 5307.8 is added to the Labor Code, to read:

5307.8. Notwithstanding Section 5307.1, on or before July 1, 2013, the administrative director shall adopt, after public hearings, a schedule for payment of home health care services provided in accordance with Section 4600 that are not covered by a Medicare fee schedule and are not otherwise covered by the official medical fee schedule adopted pursuant to Section 5307.1. The schedule shall set forth fees and requirements for service providers, and shall be based on the maximum service hours and fees as set forth in regulations adopted pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code. No fees shall be provided for any services, including any services provided by a member of the employee's household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of injury. If appropriate, an attorney's fee for recovery of home health care fees under this section may be awarded in accordance with Section 4906 and any applicable rules or regulations.

SEC. 77. Section 5307.9 is added to the Labor Code, to read:

5307.9. On or before December 31, 2013, the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt, after public hearings, a schedule of reasonable maximum fees payable for copy and related services, including, but not limited to, records or documents that have been reproduced or recorded in paper, electronic, film, digital, or other format. The schedule shall specify the services allowed

and shall require specificity in billing for these services, and shall not allow for payment for services provided within 30 days of a request by an injured worker or his or her authorized representative to an employer, claims administrator, or workers' compensation insurer for copies of records in the employer's, claims administrator's, or workers' compensation insurer's possession that are relevant to the employee's claim. The schedule shall be applicable regardless of whether payments of copy service costs are claimed under the authority of Section 4600, 4620, or 5811, or any other authority except a contract between the employer and the copy service provider.

SEC. 78. Section 5318 of the Labor Code is repealed.

SEC. 79. Section 5402 of the Labor Code is amended to read:

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

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

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

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

SEC. 80. Section 5502 of the Labor Code is amended to read:

5502. (a) Except as provided in subdivisions (b) and (d), the hearing shall be held not less than 10 days, and not more than 60 days, after the date a declaration of readiness to proceed, on a form prescribed by the appeals board, is filed. If a claim form has been filed for an injury occurring on or after January 1, 1990, and before

January 1, 1994, an application for adjudication shall accompany the declaration of readiness to proceed.

(b) The administrative director shall establish a priority calendar for issues requiring an expedited hearing and decision. A hearing shall be held and a determination as to the rights of the parties shall be made and filed within 30 days after the declaration of readiness to proceed is filed if the issues in dispute are any of the following, provided that when an expedited hearing is requested pursuant to paragraph (2), no other issue may be heard until the medical provider network dispute is resolved:

(A) The employee's entitlement to medical treatment pursuant to Section 4600, except for treatment issues determined pursuant to Sections 4610 and 4610.5.

(B) Whether the injured employee is required to obtain treatment within a medical provider network.

(C) A medical treatment appointment or medical-legal examination.

(D) The employee's entitlement to, or the amount of, temporary disability indemnity payments.

(4) The employee's entitlement to compensation from one or more responsible employers when two or more employers dispute liability as among themselves.

(5) Any other issues requiring an expedited hearing and determination as prescribed in rules and regulations of the administrative director.

(c) The administrative director shall establish a priority conference calendar for cases in which the employee is represented by an attorney and the issues in dispute are employment or injury arising out of employment or in the course of employment. The conference shall be conducted by a workers' compensation administrative law judge within 30 days after the declaration of readiness to proceed. If the dispute cannot be resolved at the conference, a trial shall be set as expeditiously as possible, unless good cause is shown why discovery is not complete, in which case status conferences shall be held at regular intervals. The case shall be set for trial when discovery is complete, or when the workers' compensation administrative law judge determines that the parties have had sufficient time in which to complete reasonable discovery. A determination as to the rights of the parties shall be made and filed within 30 days after the trial.

(d) (1) In all cases, a mandatory settlement conference, except a lien conference or a mandatory settlement lien conference, shall be conducted not less than 10 days, and not more than 30 days, after the filing of a declaration of readiness to proceed. If the dispute is not resolved, the regular hearing, except a lien trial, shall be held within 75 days after the declaration of readiness to proceed is filed.

(2) The settlement conference shall be conducted by a workers' compensation administrative law judge or by a referee who is eligible to be a workers' compensation administrative law judge or eligible to be an arbitrator under Section 5270.5. At the mandatory settlement conference, the referee or workers' compensation administrative law judge shall have the authority to resolve the dispute, including the authority to approve a compromise and release or issue a stipulated finding and award, and if the dispute cannot be resolved, to frame the issues and stipulations for trial. The appeals board shall adopt any regulations needed to implement this subdivision. The presiding workers' compensation administrative law judge shall supervise settlement conference referees in the performance of their judicial functions under this subdivision.

(3) If the claim is not resolved at the mandatory settlement conference, the parties shall file a pretrial conference statement noting the specific issues in dispute, each party's proposed permanent disability rating, and listing the exhibits, and disclosing witnesses. Discovery shall close on the date of the mandatory settlement conference. Evidence not disclosed or obtained thereafter shall not be admissible unless the proponent of the evidence can demonstrate that it was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference.

(e) In cases involving the Director of Industrial Relations in his or her capacity as administrator of the Uninsured Employers Fund, this section shall not apply unless proof of service, as specified in paragraph (1) of subdivision (d) of Section 3716, has been filed with the appeals board and provided to the Director of Industrial Relations, valid jurisdiction has been established over the employer, and the fund has been joined.

(f) Except as provided in subdivision (a) and in Section 4065, the provisions of this section shall apply irrespective of the date of injury.

SEC. 81. Section 5703 of the Labor Code is amended to read:

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

(a) Reports of attending or examining physicians.

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

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

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

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

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

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

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

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

(h) Relevant portions of medical treatment protocols published by medical specialty societies. To be admissible, the party offering such a protocol or portion of a protocol shall concurrently enter into evidence information regarding how the protocol was developed, and to what extent the protocol is evidence-based, peer-reviewed, and nationally recognized. If a party offers into evidence a portion of a treatment protocol, any other party may offer into evidence additional portions of the protocol. The party offering a protocol, or portion thereof, into evidence shall either

make a printed copy of the full protocol available for review and copying, or shall provide an Internet address at which the entire protocol may be accessed without charge.

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

(j) Reports of vocational experts. If vocational expert evidence is otherwise admissible, the evidence shall be produced in the form of written reports. Direct examination of a vocational witness shall not be received at trial except upon a showing of good cause. A continuance may be granted for rebuttal testimony if a report that was not served sufficiently in advance of the close of discovery to permit rebuttal is admitted into evidence.

(1) Statements concerning any bill for services are admissible only if they comply with the requirements applicable to statements concerning bills for services pursuant to subdivision (a).

(2) Reports are admissible under this subdivision only if the vocational expert has further stated in the body of the report that the contents of the report are true and correct to the best knowledge of the vocational expert. The statement shall be made in compliance with the requirements applicable to medical reports pursuant to subdivision (a).

SEC. 82. Section 5710 of the Labor Code is amended to read:

5710. (a) The appeals board, a workers' compensation judge, or any party to the action or proceeding, may, in any investigation or hearing before the appeals board, cause the deposition of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in civil actions in the superior courts of this state under Title 4 (commencing with Section 2016.010) of Part 4 of the Code of Civil Procedure. To that end the attendance of witnesses and the production of records may be required. Depositions may be taken outside the state before any officer authorized to administer oaths. The appeals board or a workers' compensation judge in any proceeding before the appeals board may cause evidence to be taken in other jurisdictions before the agency authorized to hear workers' compensation matters in those other jurisdictions.

(b) If the employer or insurance carrier requests a deposition to be taken of an injured employee, or any person claiming benefits

as a dependent of an injured employee, the deponent is entitled to receive in addition to all other benefits:

(1) All reasonable expenses of transportation, meals, and lodging incident to the deposition.

(2) Reimbursement for any loss of wages incurred during attendance at the deposition.

(3) One copy of the transcript of the deposition, without cost.

(4) A reasonable allowance for attorney's fees for the deponent, if represented by an attorney licensed by the State Bar of this state. The fee shall be discretionary with, and, if allowed, shall be set by, the appeals board, but shall be paid by the employer or his or her insurer.

(5) If interpretation services are required because the injured employee or deponent does not proficiently speak or understand the English language, upon a request from either, the employer shall pay for the services of 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. The fee to be paid by the employer shall be in accordance with the fee schedule adopted by the administrative director and shall include any other deposition-related events as permitted by the administrative director.

SEC. 83. Section 5811 of the Labor Code is amended to read:

5811. (a) No fees shall be charged by the clerk of any court for the performance of any official service required by this division, except for the docketing of awards as judgments and for certified copies of transcripts thereof. In all proceedings under this division before the appeals board, costs as between the parties may be allowed by the appeals board.

(b) (1) It shall be the responsibility of any party producing a witness requiring an interpreter to arrange for the presence of a qualified interpreter.

(2) A qualified interpreter is a language interpreter who is 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. The duty of an interpreter is to accurately and impartially translate oral communications and transliterate written materials, and not to act as an agent or advocate. An interpreter shall not disclose to any

person who is not an immediate participant in the communications the content of the conversations or documents that the interpreter has interpreted or transliterated unless the disclosure is compelled by court order. An attempt by any party or attorney to obtain disclosure is a bad faith tactic that is subject to Section 5813.

Interpreter fees that are reasonably, actually, and necessarily incurred shall be paid by the employer under this section, provided they are in accordance with the fee schedule adopted by the administrative director.

A qualified interpreter may render services during the following:

(A) A deposition.

(B) An appeals board hearing.

(C) A medical treatment appointment or medical-legal examination.

(D) During those settings which the administrative director determines are reasonably necessary to ascertain the validity or extent of injury to an employee who does not proficiently speak or understand the English language.

SEC. 84. This act shall apply to all pending matters, regardless of date of injury, unless otherwise specified in this act, but shall not be a basis to rescind, alter, amend, or reopen any final award of workers' compensation benefits.

SEC. 85. Section 66.5 of this bill incorporates amendments to Section 4903.1 of the Labor Code proposed by both this bill and Senate Bill 1105. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2013, (2) each bill amends Section 4903.1 of the Labor Code, and (3) this bill is enacted after Senate Bill 1105, in which case Section 66 of this bill shall not become operative.

~~SEC. 85.~~

SEC. 86. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

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