

Workers Compensation Legislation

SB 899

4/19/04

Courtesy of Med-Legal, Inc.



Please use us for your Subpoena, copying and scanning needs

www.GetRecords.com

800-244-3495



Table of Contents

LEGISLATIVE COUNSEL'S DIGEST 1
Funding Return-to-work Program 1
Study effect of reforms on insurance rates 2
Qualified medical examiners 2
Civil penalties 2
Determination of disputed medical issues 2
Return to work 2
Vocational Rehabilitation 3
Fraud 3
Collective bargaining 3
Liberal construction 3
Compensability; AME/QME 3
Presumption of treating physician 4
Reimbursement of medical services 4
Cure and relieve 4
Choice of physician 4
Utilization guidelines 4
Chiropractic and physical therapy visits 5
Temporary Disability weeks 5
Permanent Disability Schedule 5
Apportionment 6
Claim form; initial treatment 6
Penalties 6
Injury prevention program 7
NEW LAW 8
62.5 Revolving Fund; Uninsured employers' benefits trust fund;
subsequent injuries benefits trust fund..... 8
138.65 Study on Legislative Reforms on workers compensation insurance
rates..... 9
139.2 QME qualifications 10
139.48 Return to work program 16
139.5 (repealed) 18
139.5 Vocational rehabilitation unit. 19
2699 Private attorney general for enforcement of labor law 22
3201.5 Collective bargaining agreement 23
3201.7 Labor management agreements for workers compensation benefits
- arbitration..... 26
3201.9 Reports under collective bargaining agreements 28
3202.5 Preponderance of evidence standard 29
3207 Compensation 29
3823 Medical billing and provider fraud 30
4060 Comprehensive medical legal evaluations for disputes over the
compensability of an injury..... 30
4061 Medical evaluation of permanent disability 31

4062	Objections to medical determination; procedures when employer objects to treating physician's recommendations	35
4062.01	(Repealed) Objections to medical determination.....	38
4062.1	Medical evaluation procedures for unrepresented employees...	39
4062.2	(Repealed) Information provided to AME.....	40
4062.2	Medical evaluation procedures for represented employees.....	41
4062.3	Information provided to QME.....	42
4062.5	Failure of QME to complete timely evaluation.....	43
4062.8	Educational materials to treating physicians.....	43
4062.9	Treating Physician presumption (Repealed).....	43
4600	Medical treatment provided by employer.....	44
4603.2	Notice to employer of selected physician.....	46
4604.5	Medical treatment utilization schedule.....	48
4616	Medical provider networks.....	49
4616.1	<i>Economic profiling used in provider network</i>	50
4616.2	Continuity of care policy for provider networks.....	50
4616.3	Choice of physician within provider network.....	52
4616.4	Independent Medical Reviews.....	52
4616.5	Employer.....	55
4616.6	No additional reports or examinations.....	55
4616.7	Approved provider network health care organizations.....	55
4650	Timing of payments.....	55
4656	Maximum period for temporary disability payments.....	57
4658	Permanent Disability.....	57
4658.1	Definitions of regular, modified and alternative work.....	60
4660	Percentage of permanent disability; schedule.....	61
4663	Aggravation of preexisting disease (repealed).....	62
4663	Apportionment based on causation.....	62
4664	Apportionment based on prior award.....	63
4706.5	Payment of death benefits where no surviving dependant.....	63
4750	Employers liability for combined disabilities (repealed).....	64
4750.5	Subsequent noncompensable injuries.....	64
4903.05	Filing fee for initial liens - fee; exempt providers; collection procedures.	65
5402	Employers knowledge equivalent to notice; employers notice to employee.	65
5703	Specified additional evidence received.....	65
5814	(Repealed on June 1, 2004) Unreasonable delay or refusal of payment of compensation.	66
5814	(Effective on June 1, 2004) Unreasonable delay or refusal of payment of compensation.	67
5814.6	Administrative penalties.....	67
6401.7	Injury prevention programs.....	68
	Repeal of presumption retroactive.....	71
	Changes apply prospectively.....	71
	Provisions are severable.....	72
	Urgency statute.....	72

New PD Chart73

BILL NUMBER: SB 899 ENROLLED
BILL TEXT

PASSED THE SENATE APRIL 16, 2004
PASSED THE ASSEMBLY APRIL 16, 2004
CONFERENCE REPORT NO. 1
PROPOSED IN CONFERENCE APRIL 15, 2004
AMENDED IN ASSEMBLY JULY 14, 2003
AMENDED IN SENATE APRIL 21, 2003

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

FEBRUARY 21, 2003

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

LEGISLATIVE COUNSEL'S DIGEST

SB 899, Poochigian. Workers' compensation.

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

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

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

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

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

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

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

Existing law requires the administrative director to appoint qualified medical evaluators in each of the respective specialties as required for the evaluation of medical-legal issues. Existing law further requires the administrative director to adopt regulations concerning procedures to be followed by all qualified medical evaluators in evaluating the existence and extent of permanent impairment and limitations resulting from the injury, and specifies the factors upon which these evaluations are to be based.

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

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

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

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

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

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

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

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

This bill would provide that the fund shall consist of certain

penalties imposed in connection with delayed or refused compensation payments and transfers made by the administrative director from the Workers' Compensation Administration Revolving Fund.

Existing law, until January 1, 2004, required the administrative director to establish a vocational rehabilitation unit to perform duties in connection with vocational rehabilitation services, and provided that when an employee was determined to be medically eligible and chose to participate in a vocational rehabilitation program, he or she would continue to receive temporary disability benefits, a maintenance allowance, and additional living expenses. Chapter 639 of the Statutes of 2003, which became effective on January 1, 2004, eliminated vocational rehabilitation as part of the workers' compensation system.

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

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

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

Existing law authorizes collective bargaining agreements between a private employer or groups of employers engaged in construction-related activities and a recognized or certified exclusive bargaining representative that establishes a dispute resolution process for workers' compensation instead of the hearing before the Workers' Compensation Appeals Board and its workers' compensation administrative law judges, or that provides for other alternative workers' compensation programs. Existing law also authorizes similar dispute resolution provisions contained in labor-management agreements.

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

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

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

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

Existing law establishes procedures for the resolution of disputes regarding the compensability of an injury. Existing law also establishes procedures, including procedures regarding the selection of agreed and qualified medical evaluators, that apply if the parties do not agree to a permanent disability rating based on the treating

physician's evaluation and the employee is represented by an attorney, as well as when the employee is not represented by an attorney.

This bill would revise and recast these provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Existing workers' compensation law authorizes the administrative director to prepare, adopt, and from time to time amend a schedule for the determination of the percentage of permanent disabilities in accordance with specified provisions.

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

Existing law provides that when determining the percentages of permanent disability, account shall be taken of various factors, including the nature of the physical injury or disfigurement and with consideration being given to the diminished ability of the injured employee to compete in an open labor market.

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

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

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

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

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

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

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

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

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

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

Existing law provides that when payment has been unreasonably delayed or refused, the full amount of the order, decision, or award shall be increased by 10%.

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

a self-imposed penalty in lieu of the penalty that may be awarded by the appeals board.

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

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

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

Existing law requires every employer to establish, implement, and maintain an effective injury prevention program. Existing law also authorizes an employer to adopt the Model Injury and Illness Prevention Program for Non-High-Hazard Employment and the Model Injury and Illness Prevention Program for Employers in Industries with Intermittent Employment, developed by the Division of Occupational Safety and Health. Existing law requires every workers' compensation insurer to conduct a review of these injury and illness prevention programs of each of its insureds within 4 months of the commencement of the initial insurance policy term.

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

The bill would also make various conforming changes.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

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

62.5 Revolving Fund; Uninsured employers' benefits trust fund; subsequent injuries benefits trust fund.

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

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

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

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

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

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

purpose. All moneys collected shall be retained in the trust fund until paid as benefits to workers who have suffered serious injury and who are suffering from previous and serious permanent disabilities or physical impairments. Nonadministrative expenses include audits and reports of services pursuant to subdivision (c) of Section 4755. The surcharge amount for this fund shall be stated separately.

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

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

(e) (1) Separate surcharges shall be levied by the director upon all employers, as defined in Section 3300, for purposes of deposit in the Workers' Compensation Administration Revolving Fund, the Uninsured Employers Benefits Trust Fund, and the Subsequent Injuries Benefits Trust Fund. The total amount of the 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 regulations adopted pursuant to paragraph (1) shall be exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

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

138.65 Study on Legislative Reforms on workers compensation insurance rates.

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

- (1) *Identify and quantify the savings generated by the reforms.*
- (2) *Review workers' compensation insurance rates to determine the extent to which the reform savings were reflected in rates. When reviewing the rates, consideration shall be given to an insurer's premium revenue, claim costs, and surplus levels.*
- (3) *Assess the effect of the reform savings on replenishing surpluses for workers' compensation insurance coverage.*

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

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

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

(c) The administrative director shall submit to the Governor, the Insurance Commissioner, and the President pro Tempore of the Senate, the Speaker of the Assembly, and the chairs of the appropriate policy committees of the Legislature, a progress report on the study on January 1, 2005, and July 1, 2005, and the final study on or before January 1, 2006. The Governor and the Insurance Commissioner shall review the results of the study and make recommendations as to the appropriateness of regulating insurance rates. If, after reviewing the study, the Governor and the Insurance Commissioner determine that the rates do not appropriately reflect the savings and the timing of the savings associated with the 2003 and 2004 reforms, the Governor and the Insurance Commissioner may submit proposals to the Legislature. The proposals shall take into consideration how rates should be regulated, and by whom. In no event shall the proposals unfairly penalize insurers that have properly reflected the 2003 and 2004 reforms in their rates, or can verify that they have not received any cost savings as a result of the reforms.

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

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

139.2 QME qualifications.

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

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

(1) Prior to his or her appointment as a qualified medical evaluator, passes an examination written and administered by the administrative director for the purpose of demonstrating competence in evaluating medical-legal issues in the workers' compensation system. Physicians shall not be required to pass an additional examination as a condition of reappointment. A physician seeking appointment as a qualified medical evaluator on or after January 1,

2001, shall also complete prior to appointment, a course on disability evaluation report writing approved by the administrative director. The administrative director shall specify the curriculum to be covered by disability evaluation report writing courses, which shall include, but is not limited to, 12 or more hours of instruction.

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

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

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

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

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

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

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

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

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

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

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

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

(C) Has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders, and has served as an agreed medical evaluator on eight or more occasions prior to January 1, 1990.

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

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

(c) The administrative director shall adopt standards for appointment of physicians who are retired or who hold teaching positions who are exceptionally well qualified to serve as a qualified medical evaluator even though they do not otherwise qualify

under paragraph (2) of subdivision (b). In no event shall a physician whose full-time practice is limited to the forensic evaluation of disability be appointed as a qualified medical evaluator under this subdivision.

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

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

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

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

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

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

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

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

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

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

60 days after receipt of the physician's response.

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

(h) (1) When ~~the injured workers is not represented by an attorney requested by an employee or employer pursuant to Section 4062.1~~, the medical director appointed pursuant to Section 122 shall assign three-member panels of qualified medical evaluators within five working days after receiving a request for a panel. If a panel is not assigned within 15 working days, the employee shall have the right to obtain a medical evaluation from any qualified medical evaluator of his or her choice. The medical director shall use a random selection method for assigning panels of qualified medical evaluators. The medical director shall select evaluators who are specialists of the type ~~selected~~ requested by the employee. The medical director shall advise the employee that he or she should consult with his or her treating physician prior to deciding which type of specialist to request.

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

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

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

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

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

(4) When the medical director determines that an employee has requested an evaluation by a type of specialist that is appropriate for the employee's injury, but there are not enough qualified medical evaluators of that type within the general geographic area of the employee's residence to establish a three-member panel, the medical director shall include sufficient qualified medical evaluators from other geographic areas and the employer shall pay all necessary travel costs incurred in the event the employee selects an evaluator from another geographic area.

(i) The medical director appointed pursuant to Section 122 shall continuously review the quality of comprehensive medical evaluations

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

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

(1) (A) Standards governing the timeframes within which medical evaluations shall be prepared and submitted by agreed and qualified medical evaluators. Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure.

The administrative director shall develop regulations governing the provision of extensions of the 30-day period in *both of the following cases*: ~~(A) Where~~

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

(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 ~~this subdivision~~ subparagraph (A), "good cause" means *any of the following*:

~~(i) Medical~~

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

~~(ii) Death~~

(ii) Death in the evaluator's family.

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

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

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

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

(4) Procedures to be used in determining the compensability of psychiatric injury. The procedures shall be in accordance with

Section 3208.3 and shall require that the diagnosis of a mental disorder be expressed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(l) The administrative director shall cite the qualified medical evaluator for a violation listed in subdivision (k) and shall set a hearing on the alleged violation within 30 days of service of the citation on the qualified medical evaluator. In addition to the authority to terminate or suspend the qualified medical evaluator upon finding a violation listed in subdivision (k), the administrative director may, in his or her discretion, place a qualified medical evaluator on probation subject to appropriate

conditions, including ordering continuing education or training. The administrative director shall report to the appropriate licensing board the name of any qualified medical evaluator who is disciplined pursuant to this subdivision.

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

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

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

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

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

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

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

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

- ~~(1) The reimbursement shall be allowed for up to 50 percent of wages paid to the employee.~~
- ~~(2) The reimbursement shall be allowed for a period of no more than 90 days, or until the employee is released to the full duties of his or her usual occupation, or until the employee's condition becomes permanent and stationary, whichever occurs first.~~
- ~~(3) The modified or alternative work is compatible with the employee's documented work restrictions imposed by the treating physician as a result of the work injury or illness.~~
- ~~(4) The reimbursement shall be paid from the Workers' Compensation Return-to-Work Fund, created in subdivision (i), as a reimbursement to the employer after submission of documentation of eligibility and wages paid.~~
- ~~(d)~~

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

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

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

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

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

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

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

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

~~least 85 percent of the employee's pre injury wages and compensation.~~
~~(f)~~

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

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

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

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

~~(h)~~

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

~~(i)~~

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

(j)

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

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

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

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

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

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

~~(2) Up to six thousand dollars (\$6,000) for permanent partial disability awards between 15 and 25 percent.~~
~~(3) Up to eight thousand dollars (\$8,000) for permanent partial disability awards between 26 and 49 percent.~~
~~(4) Up to ten thousand dollars (\$10,000) for permanent partial disability awards between 50 and 99 percent.~~
~~(b) The voucher may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement. No more than 10 percent of the voucher moneys may be used for vocational or return to work counseling. The administrative director shall adopt regulations governing the form of payment, direct reimbursement to the injured employee upon presentation to the employer of appropriate documentation and receipts, and any other matters necessary to the proper administration of the supplemental job displacement benefit.~~
~~(c) Within 10 days of the last payment of temporary disability the employer shall provide to the employee in the form and manner prescribed by the administrative director information that provides notice of rights under this section. This notice shall be sent by certified mail.~~
~~(d) This section shall apply to injuries occurring on or after January 1, 2004.~~

**SEC. 5. Section 139.5 is added to the Labor Code, to read:
139.5 Vocational rehabilitation unit.**

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

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

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

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

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

(5) To develop a fee schedule, to be adopted by the administrative director, governing reasonable fees for vocational rehabilitation services provided on and after January 1, 1991. The initial fee schedule adopted under this paragraph shall be designed to reduce the cost of vocational rehabilitation services by 10 percent from the level of fees paid during 1989. On or before July 1, 1994, the administrative director shall establish the maximum aggregate

permissible fees that may be charged for counseling. Those fees shall not exceed four thousand five hundred dollars (\$4,500) and shall be included within the sixteen thousand dollar (\$16,000) cap. The fee schedule shall permit up to (A) three thousand dollars (\$3,000) for vocational evaluation, evaluation of vocational feasibility, initial interview, vocational testing, counseling and research for plan development, and preparation of the Division of Workers' Compensation Form 102, and (B) three thousand five hundred dollars (\$3,500) for plan monitoring, job seeking skills, and job placement research and counseling. However, in no event shall the aggregate of (A) and (B) exceed four thousand five hundred dollars (\$4,500).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that date.

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

2699 Private attorney general for enforcement of labor law.

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

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

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

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

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

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

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

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

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

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

(h) Except as provided in subdivision (i), civil penalties recovered by aggrieved employees shall be distributed as follows: 50 percent to the General Fund, 25 percent to the Labor and Workforce

Development Agency for education of employers and employees about their rights and responsibilities under this code, available for expenditure upon appropriation by the Legislature, and 25 percent to the aggrieved employees.

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

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

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

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

3201.5 Collective bargaining agreement.

(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.

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

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

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

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

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

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

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

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

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

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

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

(2) Upon its original application and annually thereafter, a valid

and active license where that license is required by law as a condition of doing business in the state within the industries set forth in subdivision (a) of Section 3201.5.

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

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

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

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

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

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

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

(i) By June 30, 1996, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify Members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

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

(2) The number of claims filed.

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

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

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

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

(7) Safety history.

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

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

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

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

containing provisions authorized by this section.

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

3201.7 Labor management agreements for workers compensation benefits - arbitration.

(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.

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

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

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

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

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

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

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

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

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

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

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

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

(2) The number of claims filed.

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

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

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

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

(7) Safety history.

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

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

(10) Overall worker satisfaction.

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

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

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

3201.9 Reports under collective bargaining agreements.

(a) On or before June 30, 2004, and biannually thereafter, the report required in subdivision (i) of Section 3201.5

and subdivision (h) of Section 3201.7 shall include updated loss experience for all employers and groups of employers participating in a program established under those sections. The report shall include updated data on each item set forth in subdivision (i) of Section 3201.5 and subdivision (h) of Section 3201.7 for the previous year for injuries in 2003 and beyond. Updates for each program shall be done for the original program year and for subsequent years.

The insurers, the Department of Insurance, and the rating organization designated by the Insurance Commissioner pursuant to Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 of the Insurance Code, shall provide the administrative director with any information that the administrative director determines is reasonably necessary to conduct the study.

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

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

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

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

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

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

3202.5. Preponderance of evidence standard

~~Nothing contained in Section 3202 shall be construed as relieving a party or a lien claimant from meeting the evidentiary burden of proof by a preponderance of the evidence. All parties and lien claimants shall meet the evidentiary burden of proof on all issues by a preponderance of the evidence in order that all parties are considered equal before the law. "Preponderance of the evidence" means such that evidence as that, when weighed with that opposed to it, has more convincing force and the greater probability of truth. When weighing the evidence, the test is not the relative number of witnesses, but the relative convincing force of the evidence.~~

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

3207 "Compensation".

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

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

3823 Medical billing and provider fraud.

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

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

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

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

4060 Comprehensive medical legal evaluations for disputes over the compensability of an injury.

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

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

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

(d) If a medical evaluation is required to determine compensability at any time after ~~period specified in Subdivision (b) the claim form is filed,~~ and the employee is not represented by an attorney, ~~the employer shall not seek agreement with the employee on a physician to prepare a comprehensive medical legal evaluation. The employee may select a qualified medical evaluator to prepare a comprehensive medical legal evaluation. The division shall assist unrepresented employees, and shall make available to them the list of medical evaluators compiled under Section 139.2. Neither party may obtain more than one comprehensive medical legal report, provided, however, that any party may obtain additional reports at their own expense. If an employee has received a comprehensive medical legal evaluation under this subdivision, and he or she later becomes represented by an attorney, he or she shall not be entitled to an additional evaluation at the employer's expense the employer shall provide the employee with notice either that the employer requests a comprehensive medical evaluation to determine compensability or that the employer has not accepted liability and the employee may request a comprehensive medical evaluation to determine compensability. Either party may request a comprehensive medical evaluation to determine compensability. The evaluation shall be obtained only by the procedure provided in Section 4062.1.~~

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

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

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

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

4061 Medical evaluation of permanent disability.

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

(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. The notice shall include information concerning how the employee may obtain a formal medical evaluation pursuant to subdivision (c) or (d) if he or she disagrees with the position taken by the employer. The notice shall be accompanied by the form prescribed by the administrative director for requesting assignment of a panel of qualified medical evaluators, unless the employee is represented by an attorney. If the employer determines permanent

disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the determination was made and whether there is need for continuing medical care.

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

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

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

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

(d) ~~If the parties do not agree to a permanent disability rating based on the treating physician's evaluation, and if the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare an additional~~

~~medical evaluation. The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury.~~

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

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

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

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

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

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

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

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

~~(l)~~

(g) Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating or obtain additional information from the treating physician or medical evaluator to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the procedures promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2. This request shall be in writing, shall specify the reasons the rating should be reconsidered, and shall be served on the other party. If the administrative director finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the administrative director shall return the report to the treating physician or qualified medical evaluator for appropriate action as the administrative director instructs. Upon receipt of the treating physician's or qualified medical evaluator's final comprehensive medical evaluation and summary form, the administrative director shall recalculate the permanent disability rating according to Section 4660 and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer.

~~(m)~~

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

~~(n)~~

(2) *If* the employee and employer agree to a stipulated findings and award as provided under Section 5702 or to compromise and release the claim under Chapter 2 (commencing with Section 5000) of Part 3, or if the employee wishes to commute the award under Chapter 3 (commencing with Section 5100) of Part 3, the appeals board shall first determine whether the agreement or commutation is in the best interests of the employee and whether the proper procedures have been

followed in determining the permanent disability rating. The administrative director shall promulgate a form to notify the employee, at the time of service of any rating under this section, of the options specified in this subdivision, the potential advantages and disadvantages of each option, and the procedure for disputing the rating.

~~(n)~~

(i) No issue relating to the existence or extent of permanent impairment and limitations ~~or the need for continuing medical care~~ resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician or an agreed or qualified medical evaluator. With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations ~~or the need for continuing medical care~~ resulting from the injury shall be obtained ~~prior to service of the comprehensive medical evaluation on the employee and employer if the employee is unrepresented, or prior to the attempt to select an agreed medical evaluator if the employee is represented, except in accordance with Section 4062.1 or 4062.2.~~ Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. ~~However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury and comprehensive medical evaluations prepared by a qualified medical evaluator selected by an unrepresented employee from a three-member panel shall be admissible.~~

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

4062 Objections to medical determination; procedures when employer objects to treating physician's recommendations"4062 Objections to medical determination; procedures when employer objects to treating physician's recommendations.

(a) If either the employee or employer objects to a medical determination made by the treating physician concerning ~~the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, the extent and scope of medical treatment, the any medical existence of new and further disability, or any~~ other issues not covered by Section 4060 or 4061 *and not subject to Section 4610*, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610. *If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision.* These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, ~~the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report~~