Proposed language in bill format

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123

123. The administrative director may employ necessary assistants, officers, experts, statisticians, actuaries, accountants, medical billing specialists, workers' compensation administrative law judges, stenographic shorthand reporters, legal secretaries, disability evaluation raters, program technicians, and other employees to implement new, efficient court management systems. The salaries of the workers' compensation administrative law judges shall be fixed by the Department of Personnel Administration for a class of positions which perform judicial functions.

4061

4061. (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, and whether in indemnity payment will be deferred pursuant to subdivision (b) of Section 4650..

(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine 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, and the employee is represented by an attorney, 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 immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. Either party may request a comprehensive medical evaluation to determine permanent disability, and the evaluation shall be obtained only by the procedure provided in Section 4062.1.

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

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

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

(h) (1) If a comprehensive medical evaluation from the treating physician or an agreed medical evaluator or a qualified medical evaluator selected from a three-member panel resolves any issue so as to require an employer to provide compensation, the employer shall commence the payment of compensation subject to the provisions of subdivision (b) of Section 4650 or promptly commence proceedings before the appeals board to resolve the dispute.

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

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

(i) No issue relating to the existence or extent of permanent impairment and limitations resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician 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 resulting from the injury shall be obtained, except in accordance with Section 4062.1 or 4062.2. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board.

4062

4062. ~~(a)~~ If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. 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, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained.

~~(b) The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation. Examinations shall be scheduled on an expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. If the second opinion report recommends surgery, the employer shall authorize the surgery. If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed. The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision.~~

~~(c) The second opinion physician shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:~~

~~(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.~~

~~(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.~~

~~(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.~~

~~(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.~~

~~(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.~~

~~(6) The employee or the employee's immediate family.~~

4062.1. (a) If an employee is not represented by an attorney, the employer shall not seek agreement with the employee on an agreed medical evaluator, nor shall an agreed medical evaluator prepare the formal medical evaluation on any issues in dispute.

(b) If either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062, either party may submit the form prescribed by the administrative director requesting the medical director to assign a panel of three qualified medical evaluators in accordance with Section 139.2. ~~However, the employer may not submit the form unless the employee has not submitted the form within 10 days after the employer has furnished the form to the employee and requested the employee to submit the form.~~ The party submitting the request form shall designate the specialty of the physicians that will be assigned to the panel. If both parties submit requests within 10 days of the date the employer furnishes the form to the employee for the employee to request a panel, and the parties have requested different specialties, the medical director shall assign a panel in the specialty deemed by the medical director to be appropriate, or if both requested specialties are appropriate, the medical director may assign a panel of physicians randomly selected from both specialties.

(c) Within 10 days of the issuance of a panel of qualified medical evaluators, the employee shall select a physician from the panel to prepare a medical evaluation, the employee shall schedule the appointment, and the employee shall inform the employer of the selection and the appointment. If the employee does not inform the employer of the selection within 10 days of the assignment of a panel of qualified medical evaluators, then the employer may select the physician from the panel to prepare a medical evaluation. If the employee informs the employer of the selection within 10 days of the assignment of the panel but has not made the appointment, or if the employer selects the physician pursuant to this subdivision, then the employer shall arrange the appointment. Upon receipt of written notice of the appointment arrangements from the employee, or upon giving the employee notice of an appointment arranged by the employer, the employer shall furnish payment of estimated travel expense.

(d) 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.

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

4062.2

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

(b) If either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062, ~~either party may commence the selection process for an agreed medical evaluator by making a written request naming at least one proposed physician to be the evaluator. The parties shall seek agreement with the other party on the physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days of the first written proposal that names a proposed agreed medical evaluator, or any additional time not to exceed 20 days agreed to by the parties,~~ either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation. The party submitting the request shall designate the specialty of the medical evaluator, the specialty of the medical evaluator requested by the other party if it has been made known to the party submitting the request, and the specialty of the treating physician. The party submitting the request form shall serve a copy of the request form on the other party.

(c) Within 10 days of assignment of the panel by the administrative director, ~~the parties shall confer and attempt to agree upon an agreed medical evaluator selected from the panel. If the parties have not agreed on a medical evaluator from the panel by the 10th day after assignment of the panel,~~ each party may ~~then~~ strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator. If a party fails to exercise the right to strike a name from the panel within ~~three working days of gaining the right to do so~~ten days of assignment of the panel by the administrative director, the other party may select any physician who remains on the panel to serve as the medical evaluator. The administrative director may prescribe the form, the manner, or both, by which the parties shall conduct the selection process.

(d) The represented employee shall be responsible for arranging the appointment for the examination, but upon his or her failure to inform the employer of the appointment within 10 days after the medical evaluator has been selected, the employer may arrange the appointment and notify the employee of the arrangements.

(e) The parties may at any time select an agreed medical evaluator, provided that the selected physician is a qualified medical evaluator.

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

4062.5

4062.5. If a qualified medical evaluator selected from a panel or an agreed medical evaluator
fails to complete the formal medical evaluation within the timeframes established by the administrative director pursuant to paragraph (1) of subdivision (j) of Section 139.2, a new evaluation may be obtained upon the request of either party, as provided in Sections 4062.1 or 4062.2. Neither the employee nor the employer shall have any liability for payment for the formal medical evaluation which was not completed within the required timeframes unless the employee ~~or~~ and employer, on forms prescribed by the administrative director, each waive the right to a new evaluation and elects to accept the original evaluation even though it was not completed within the required timeframes.

4063

4063. If a formal medical evaluation from an agreed medical evaluator or a qualified medical evaluator selected from a three member panel resolves any issue so as to require an employer to provide compensation, the employer shall, except as otherwise provided in subdivision (b) of Section 4650, commence the payment of compensation or file an application for adjudication of claim.

4064

4064. (a) The employer shall be liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee pursuant to Sections 4060, 4061, and 4062. Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms.

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

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

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

4066

~~4066. When the employer files an application for adjudication of claim contesting the formal medical evaluation prepared by an agreed medical evaluator under this article, regardless of outcome, the workers' compensation judge or the appeals board shall assess the employee's attorney's fees against the employer, subject to Section 4906.~~

4453 (Leaving a blank for new maximum earnings figure.)

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

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

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

(3) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and, for temporary disability, not less than the lesser of one hundred sixty-eight dollars ($168) or 1.5 times the employee's average weekly earnings from all employers, but in no event less than one hundred forty-seven dollars ($147), nor more than three hundred ninety-nine dollars ($399), for injuries occurring on or after January 1, 1990.

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

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

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

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

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

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

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

Commencing on January 1, 2007, and each January 1 thereafter, the limits specified in this paragraph shall be increased by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year. For purposes of this paragraph, "state average weekly wage" means the average weekly wage paid by employers to employees covered by unemployment insurance as reported by the United States Department of Labor for California for the 12 months ending March 31 of the calendar year preceding the year in which the injury occurred.

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

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

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

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

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

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

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

(7) When the final adjusted permanent disability rating of the injured employee is 70 percent or greater, but less than 100 percent: (A) not less than one hundred five dollars ($105), nor more than two hundred fifty-two dollars ($252), for injuries occurring on or after

July 1, 1994; (B) not less than one hundred five dollars ($105), nor more than two hundred ninety-seven dollars ($297), for injuries occurring on or after July 1, 1995; (C) not less than one hundred five dollars ($105), nor more than three hundred forty-five dollars ($345), for injuries occurring on or after July 1, 1996; (D) not less than one hundred fifty dollars ($150), nor more than three hundred forty-five dollars ($345), for injuries occurring on or after January 1, 2003; (E) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than three hundred seventy-five dollars ($375), for injuries occurring on or after January 1, 2004; (F) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than four hundred five dollars ($405), for injuries occurring on or after January 1, 2005; and (G) not less than one hundred ninety-five dollars ($195), nor more than four hundred five dollars ($405), for injuries occurring on or after January 1, 2006.

(8) Not less than one hundred ninety-five dollars ($195), nor more than _____, for injuries occurring on or after January 1, 2010.

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

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

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

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

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

(d) Every computation made pursuant to this section beginning January 1, 1990, shall be made only with reference to temporary disability or the permanent disability resulting from an original injury sustained after January 1, 1990. However, all rights existing under this section on January 1, 1990, shall be continued in force. Except as provided in Section 4661.5, disability indemnity benefits shall be calculated according to the limits in this section in effect on the date of injury and shall remain in effect for the duration of any disability resulting from the injury.

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

(b) If the injury causes permanent disability, the first payment shall be made within 14 days after the date of last payment of temporary disability indemnity, except as provided in this subdivision. When the last payment of temporary disability indemnity has been made pursuant to subdivision (c) of Section 4656, and regardless of whether the extent of permanent disability can be determined at that date, the employer nevertheless shall commence the timely payment required by this subdivision and shall continue to make these payments until the employer's reasonable estimate of permanent disability indemnity due has been paid, and if the amount of permanent disability indemnity due has been determined, until that amount has been paid. Prior to an award of permanent disability indemnity, no permanent disability indemnity shall be required while the employee is employed by the employer at regular work, modified work, or alternative work, or while the employee is employed by any employer in a position that pays wages and compensation that are at least 85% of those paid to the employee at the time of injury, or while the employee who is not employed by the employer has failed for more than ~~sixty~~ thirty days to respond to a request made by the employer in the form and manner prescribed by the administrative director for the employee to report the status of his or employment, wages and compensation, provided, however, that payment of permanent disability shall not be deferred pursuant to this sentence for more than twelve months.

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

(d) If any indemnity payment is not made timely as required by this section, the amount of the late payment shall be increased 10 percent and shall be paid, without application, to the employee, unless the employer continues the employee's wages under a salary continuation plan, as defined in subdivision (g). No increase shall apply to any payment due prior to or within 14 days after the date the claim form was submitted to the employer under Section 5401. No increase shall apply when, within the 14-day period specified under subdivision (a), the employer is unable to determine whether temporary disability indemnity payments are owed and advises the employee, in the manner prescribed in rules and regulations adopted pursuant to Section 138.4, why payments cannot be made within the 14-day period, what additional information is required to make the decision whether temporary disability indemnity payments are owed, and when the employer expects to have the information required to make the decision.

(e) If the employer is insured for its obligation to provide compensation, the employer shall be obligated to reimburse the insurer for the amount of increase in indemnity payments, made pursuant to subdivision (d), if the late payment which gives rise to the increase in indemnity payments, is due less than seven days after

the insurer receives the completed claim form from the employer. Except as specified in this subdivision, an employer shall not be obligated to reimburse an insurer nor shall an insurer be permitted to seek reimbursement, directly or indirectly, for the amount of increase in indemnity payments specified in this section.

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

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

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

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

4658

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

(1)

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

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

Column 1--Percentage of permanent disability incurred:	Column 2--Cumulative number of benefit weeks:
5	15.00
10	30.25
15	50.25
20	70.50
25	95.50
30	120.75
35	150.75
40	180.75
45	210.75
50	241.00
55	276.00
60	311.00
65	346.00
70	381.25
75	421.25
80	461.25
85	501.25
90	541.25

95	581.25
100	for life

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

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

(1)

Column 1--Range of percentage of permanent disability incurred:	Column 2--Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	3
10-19.75	4
20-24.75	5
25-29.75	6
30-49.75	7
50-69.75	8
70-99.75	9

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

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

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

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

70-99.75	9

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

(d) (1) This subdivision shall apply to injuries occurring on or after the effective date of the revised permanent disability schedule adopted by the administrative director pursuant to Section 4660. If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the basic disability payment computed as follows:

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

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

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

This paragraph shall not apply to an employer that employs fewer than 50 employees.

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

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

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

(e) This subdivision shall apply to injuries occurring on or after January 1, 2010. If the injury causes permanent disability, the percentage of disability to total disability shall be determined as prescribed according to Section 4660, and four weeks of disability payments in the amount of two-thirds of the average weekly earnings shall be allowed for each one percent of permanent disability.

4658.5

4658.5. (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 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 and before January 1, 2010.

(e) This section is repealed effective January 1, 2015, provided, however, that all rights and obligations with respect to any voucher issued prior to January 1, 2015 shall remain in force until the latest of the following:

(1) January 1, 2015,

(2) Two years after the date the voucher is issued, or

(3) Two years after the date the employer or insurer mails written notice of the expiration of the voucher to the injured worker at the last known address of the injured worker and to any school or counselor or other person known to the employer or insurer to be furnishing goods or services in reliance on the voucher. The administrative director may adopt regulations concerning notice of expiration.

4658.**6**

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

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

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

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

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

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

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

(c) This section is repealed effective January 1, 2015.

4660

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

4660. (a) In determining the percentages of permanent disability, there shall be ~~a calculation of the~~ an evaluation of the physical impairment caused by the industrial injury, ~~account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury, consideration being~~ and consideration shall be given to an employee's diminished future earning capacity, the occupation of the injured employee, and his or her age at the time of the injury.

(b) (1) For purposes of this section, the ~~nature of the physical injury or disfigurement shall incorporate~~ ~~calculation of the~~evaluation of the physical impairment caused by the industrial injury shall mean the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition). The ~~literal~~ express methodology of the calculation of impairments found in the Guides shall ~~always~~ be applied. The examples applying the methodologies found within the Guides shall be the only source used to address ambiguities.

(2) For purposes of this section, an employee's diminished future earning capacity shall be a numeric formula determined by the administrative director based on empirical data and findings that aggregate the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees. ~~The administrative director shall formulate the adjusted rating schedule based on empirical data and findings from the Evaluation of California's Permanent Disability Rating Schedule, Interim Report (December 2003), prepared by the RAND Institute for Civil Justice, and upon data from additional empirical studies.~~ "Similarly situated employees" shall mean employees with impairments to the same body part or organ system. In no case shall an employee's diminished future earning capacity be determined by an individual analysis of the employee's past or projected earnings, whether with or without comparison to other employees.

(c) ~~The administrative director shall amend the schedule for the determination of the percentage of permanent disability in accordance with this section at least once every five years.~~ The schedule for rating permanent disabilities adopted by the administrative director pursuant to this section, including any amendments to that schedule, shall be available for public inspection and, without formal introduction in evidence, shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule. The schedule may be controverted only by empirical evidence establishing that the ~~numeric values in any factor~~factual basis for calculating the numeric formula set forth in paragraph (2) of subdivision (b) ~~are outdated~~is erroneous or does not apply to the type of injury for which permanent disability is claimed.

(d) The administrative director shall amend the schedule for the determination of the percentage of permanent disability in accordance with this section not later than January 1, 2015 and thereafter at least once

every five years. If the administrative director determines that the schedule does not apply to a type of injury that causes permanent disability, the administrative director shall amend the schedule to establish a method of evaluation of the disability caused by that type of injury. The schedule shall promote consistency, uniformity, and objectivity. The schedule and any amendment thereto or revision thereof shall apply prospectively and shall apply to and govern only those permanent disabilities that result from compensable injuries received or occurring on and after the effective date of the adoption of the schedule, amendment or revision, as the fact may be. For compensable claims arising before January 1, 2005, the schedule as revised pursuant to changes made in legislation enacted during the 2003-04 Regular and Extraordinary Sessions shall apply to the determination of permanent disabilities when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by Section 4061 to the injured worker.

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

(e) Amendments to ~~this~~ subdivisions (a), (b) and (c) made by the Act adding this subdivision are declarative of existing law, except for the date of the next required revision of the schedule. It is the intent of the Legislature in enacting these amendments to abrogate the February 3, 2009 holdings of the appeals board in Mario Almaraz v. Environmental Recovery Services (aka Enviroserve) and State Compensation Insurance Fund, Case No. ADJ1078163, Joyce Guzman v. Milpitas Unified School District, Permissibly Self-Insured and Keenan & Associates, Case No. ADJ3341185, and Wanda Ogilvie v. City and County of San Francisco, Permissibly Self-Insured, Case No. ADJ1177048.

4903.05

4903.05 (a) A filing fee of one hundred dollars ($100) shall be charged for each initial lien filed pursuant to subdivision (b) of Section 4903.

(b) No filing fee shall be required for liens filed by the Veterans Administration, the Medi-Cal program, or public hospitals.

(c) The filing fee shall be collected by the administrative director. The administrative director may contract with one or more organizations to receive and process filing fees for electronic transmission and may compensate such organizations by permitting them to retain a portion of the fees collected. All net fees received by the administrative director or the division shall be deposited in the Workers' Compensation Administration Revolving Fund. All net fees received shall be used to offset the amount of surcharges assessed on employers under Section 62.5.

(d) The administrative director shall adopt regulations necessary or convenient to implement this section, including emergency regulations.

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

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

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

(3) Notwithstanding paragraphs (1) and (2), no reimbursement shall be allowed, whether payable by the employer or as a lien against the employee's recovery, for any expense incurred as provided by Article 2 (commencing with Section 4600), nor shall the employee have any liability for the expense, if at the time the expense was incurred the provider either knew or in the exercise of reasonable diligence should have known that the condition being treated was caused by the employee's present or prior employment, unless at the time the expense was incurred one or more of the following conditions were met:

(A) The expense was incurred for services authorized by the employer and performed by or at the direction of a physician authorized by the employer or

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

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

(~~3~~4) When the referee issues an award finding that an injury or

illness arises out of and in the course of employment and makes an award for temporary disability indemnity, the appeals board shall allow a lien as living expense under Section 4903, for benefits paid by a group disability policy providing loss of time benefits. Such lien shall be allowed to the extent that benefits have been paid for the same day or days for which temporary disability indemnity is awarded and shall not exceed the award for temporary disability indemnity. No lien shall be allowed hereunder unless the group disability policy provides for reduction, exclusion, or coordination of loss of time benefits on account of workers' compensation benefits.

(~~4~~5) When the parties propose that the case be disposed of by way of a compromise and release agreement, in the event the lien claimant, other than a health care provider, does not agree to the amount allocated to it, then the referee shall determine the potential recovery and reduce the amount of the lien in the ratio of the applicant's recovery to the potential recovery in full satisfaction of its lien claim.

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

(c) (1) Any lien claimant under Section 4903 or this section shall file its lien with the appeals board in writing upon a form approved by the appeals board. The lien shall be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement and proof of service upon the injured worker, or if deceased, upon the worker's dependents, the employer, the insurer, and the respective attorneys or other agents of record.

(2)A lien submitted for filing on or after January 1, 2010 for expenses provided in subdivision (b) of Section 4903 which does not comply with the requirements of this subdivision shall be deemed to be invalid, whether or not accepted for filing by the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

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

4903.5

4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after ~~six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after~~ one year from the date the services were provided~~, whichever is later~~.

(b) Notwithstanding subdivision (a), any health care provider, health care service plan, group disability insurer, employee benefit plan, or other entity providing medical benefits on a nonindustrial basis, may file a lien claim for expenses as provided in subdivision (b) of Section 4903 within six months after the person or entity first has knowledge that an industrial injury is being claimed.

(c) The injured worker shall not be liable for any underlying obligation if a lien claim has not been filed and served within the allowable period. Except when the lien claimant is the applicant as provided in Section 5501, a lien claimant shall not file a declaration of readiness to proceed in any case until the case-in-chief has been resolved.

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

(e) The changes to subdivision (a) adopted by the act adding this subdivision shall apply to all liens filed on or after one year after the effective date of the act adding this subdivision, regardless of the date the services were provided.

4903.7

4903.7(a) Any lien filed on or after January 1, 2010 for expenses as provided in subdivision (b) of Section 4903 shall accompanied by documentation sufficient to establish a prima facie right of entitlement to reimbursement for the lien and shall comply with the requirements of subdivision (b), (c) and (d).

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

(c) Supporting documentation shall include one or more declarations under penalty of perjury by a natural person or persons competent to testify to the facts stated, declaring all of the following:

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

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

(3) At least one of the following conditions was satisfied:

(A) The expense was incurred for services authorized by the employer and performed by or at the direction of a physician authorized by the employer, in which case the declaration shall include the date of the authorizations and the name and position of the person who gave the authorizations and copies of any written authorizations, or

(B) The expense was necessarily incurred for emergency medical care, as defined by subdivision (b) of Section 1317.1 of the Health and Safety Code, in which case the declaration shall include all relevant documentation to substantiate the emergency nature of the medical condition.

(d)A lien submitted for filing on or after January 1, 2010 for expenses provided in subdivision (b) of Section 4903 which does not comply with the requirements of this section shall be deemed to be invalid, whether or not accepted for filing by the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

(e) In the case of a lien filed before the requirements of subdivision (a) took effect, the lien claimant shall serve the declarations as provided in subdivision (c) upon demand by the employer or claims administrator or at least 60 days prior to the lien claimant filing a declaration of readiness, whichever occurs first. Failure to serve the documentation within thirty (30) days of service of a written demand the documentation or filing a declaration of readiness sooner than 60 days after service of the documentation shall be cause for mandatory dismissal with prejudice of the lien upon motion by any party.

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

4904

4904. (a) If notice is given in writing to the insurer, or to the employer if uninsured, setting forth the nature and extent of any claim that is allowable as a lien, the claim is a lien against any amount thereafter payable as compensation, subject to the determination of the amount and approval of the lien by the appeals board. If a lien for expenses as provided in subdivision (b) of Section 4903 is not filed and served in accordance with the rules of practice and procedure within the time allowed by Section 4903.5, the right of the lien claimant to reimbursement of the expense shall be extinguished. When the Employment Development Department has served an insurer or employer with a lien claim, the insurer or employer shall notify the Employment Development Department, in writing, as soon as possible, but in no event later than 15 working days after commencing disability indemnity payments. When a lien has been served on an insurer or an employer by the Employment Development Department, the insurer or employer shall notify the Employment Development Department, in writing, within 10 working days of filing an application for adjudication, a stipulated award, or a compromise and release with the appeals board.

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

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

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

(c) In the case of agreements for the compromise and release of a disputed claim for compensation, the applicant and defendant may propose to the appeals board, as part of the compromise and release agreement, an amount out of the settlement to be paid to any lien

claimant claiming under subdivision (f), (g), or (h) of Section 4903.

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

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

(e) The appeals board may not be prohibited from approving a compromise and release agreement on all other issues and deferring to subsequent proceedings the determination of a lien claimant's entitlement to reimbursement if the defendant in any of these proceedings agrees to pay the amount subsequently determined to be due under the lien claim.

5304. (a) The appeals board has jurisdiction over any controversy relating to or arising out of Sections 4600 to 4605 inclusive, unless an express agreement fixing the amounts to be paid for medical, surgical or hospital treatment as such treatment is described in those sections has been made between the persons or institutions rendering such treatment and the employer or insurer.

(b) ~~In a~~If a medical billing controversy relating to the amount allowed pursuant to Sections 5307.1 or 5307.6 or a fee schedule adopted pursuant to either of those sections is submitted for determination by the administrative director upon the request of either party to the controversy in accordance with regulations prescribed by the administrative director, the medical billing controversy shall not be the subject of proceedings before the appeals board except in accordance with this subdivision. ~~, a~~ A determination of a medical billing controversy by the administrative director shall be binding unless a verified appeal from the ~~medical billing~~ determination of the administrative director is filed with the appeals board having venue and served on the interested parties within 20 days after service of the determination. The appeals board shall ~~affirm~~ uphold the determination of the administrative director unless the determination of the administrative director was not supported by substantial evidence.

(c) The administrative director shall by regulation establish procedures for the submission of medical billing controversies to the administrative director, ~~including minimum amounts in controversy,~~ which may include the conditions of eligibility for administrative determination of medical billing controversies, the form and manner of submission of controversies to the administrative director, and the information which shall be submitted to the administrative director. Unless otherwise provided pursuant to regulations, all determinations of the administrative director shall be based on the information submitted by the physician or medical provider to the claims administrator with the itemization of service and on the information furnished to the provider by or on behalf of the claims administrator with its explanation for denial or reduction~~s~~ in the amount of the payment. Determinations of the administrative director pursuant to this section shall be limited to the interpretation and application of Sections 5307.1 or 5407.6 or a fee schedule adopted pursuant to either of those sections. Determinations of the administrative director may be made without hearing. The regulations may provide for electronic submission of controversies and for electronic service of determinations of the administrative director. Where an issue of fact is raised that cannot be determined on the basis of the information properly submitted to the administrative director, the administrative director shall defer the disputed issue of fact to the appeals board.

(d) Except as otherwise provided by regulations, subdivision (b) applies to all medical billing controversies which have not been taken under submission for decision by the appeals board prior to the effective date of initial regulations adopted pursuant to subdivision (c).

5307.1

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (j), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

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

(c) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in an ambulatory surgical center or in a hospital outpatient department, as the case may be.

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

exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or, with regard to pharmacy services and drugs, for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other provision of law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that both of the following conditions are met:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the Division of Workers' Compensation.

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

(A) "Medicare Economic Index" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) "Hospital market basket" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) "Hospital market basket for excluded hospitals" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) Nothing in this section shall prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components may not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but in no event shall the administrative director reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.

(l) Notwithstanding subdivision (a), the administrative director, commencing January 1, 2006, shall have the authority, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. If the administrative director fails to adopt an official medical fee schedule for physician services by January 1, 2006, the existing official medical fee schedule rates for physician services shall remain in effect until a new schedule is adopted or the existing schedule is revised.

(m) (1) Notwithstanding subdivisions (a), (b), (f), and (g), commencing January 1, 2008, the administrative director, after public hearings, may adopt and revise, no less frequently than biennially, an official medical fee schedule for inpatient facility fees for burn cases in accordance with this subdivision. Until the date that the administrative director adopts a fee schedule pursuant to this subdivision, the inpatient fee schedule adopted and revised in accordance with subdivisions (a) and (g) shall continue to apply to inpatient facility fees for burn cases.

(2) In order to establish inpatient facility fees for burn cases that are adequate to ensure a reasonable standard of services and care, the administrative director may do any of the following:

(A) Adopt a fee schedule in accordance with the Medicare payment system, or adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system.

(B) Adopt a fee schedule utilizing payment methodologies other than those utilized by the Medicare payment system.

(C) Adopt a fee schedule that utilizes both Medicare and non-Medicare methodologies.

(3) Inpatient facility fees for burn cases may exceed 120 percent, but in no case shall exceed 180 percent, of the fees paid by Medicare. Inpatient facility fees for burn cases shall be excluded from the calculation of estimated aggregate fees for purposes of other subdivisions of this section.

(4) The changes to this section made by this subdivision shall remain in effect only until January 1, 2011.

5318

5318. (a) Implantable medical devices, hardware, and instrumentation for Diagnostic Related Groups (DRGs) 004, 496, 497, 498, 519, and 520 shall be separately reimbursed at the provider's documented paid cost, plus an additional 10 percent of the provider's documented paid cost, not to exceed a maximum of two hundred fifty dollars ($250), plus any sales tax and shipping and handling charges actually paid.

(b) ~~This section shall be operative only until the administrative director adopts a regulation specifying separate reimbursement, if any, for implantable medical hardware or instrumentation for complex spinal surgeries.~~ Subdivision (a) shall not apply to medical devices, hardware, or instrumentation used in any surgical procedure performed on or after January 1, 2010.

(c) The administrative director may adopt a regulation providing for a separate or supplemental reimbursement for implantable medical hardware or instrumentation for complex spinal surgeries pursuant to Section 5307.2.

Uncodified

Amendments to Sections 4062, 4062.1, 4062.2, 4062.5, 4064 and 4066 made by this Act shall be effective January 1, 2011 and applicable to a request for a medical evaluation pursuant to Section 4060 or 4061, an objection to an opinion of the treating physician pursuant to Section 4062, and to an objection to a utilization review decision pursuant to Section 4610 if the request or objection is served on or after January 1, 2011. The medical evaluation of a dispute initiated by a request or objection served prior to January 1, 2011 shall be completed in accordance with the law in effect prior to the amendments made by this Act unless the parties agree to apply the procedures adopted pursuant to this Act.