[Cal. Labor Code §§ 4600 through 4615.]

§ 4600. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(b) As used in this division and notwithstanding any other law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27.

(c) Unless the employer or the employer's insurer has established or contracted with a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. A chiropractor shall not be a treating physician after the employee has received the maximum number of chiropractic visits allowed by subdivision (c) of Section 4604.5.

(d) (1) If an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a plan, policy, or fund as described in subdivisions (b), (c), and (d) of Section 4616.7.

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

(A) Be the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(B) Be the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history. "Personal physician" includes a medical group, if the medical group is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries.

(C) The physician agrees to be predesignated.

(3) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the employer is notified pursuant to paragraph (1), all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code. Disputes regarding the provision of medical treatment shall be resolved pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(4) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a group health insurance policy as described in Section 4616.7, all medical treatment, utilization review of

medical treatment, access to medical treatment, and other medical treatment issues shall be governed by the applicable provisions of the Insurance Code.

(5) The insurer may require prior authorization of any nonemergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to Section 4610.

(6) An employee shall be entitled to all medically appropriate referrals by the personal physician to other physicians or medical providers within the nonoccupational health care plan. An employee shall be entitled to treatment by physicians or other medical providers outside of the nonoccupational health care plan pursuant to standards established in Article 5 (commencing with Section 1367) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(e) (1) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, the employee submits to examination by a physician, he or she shall be entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.

(2) Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of Human Resources pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination.

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

(g) If the injured employee cannot effectively communicate with his or her treating physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments. To be a qualified interpreter for purposes of medical treatment appointments, an interpreter is not required to meet the requirements of subdivision (f), but shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code. The administrative director shall adopt a fee schedule for qualified interpreter fees in accordance with this section. Upon request of the injured employee, the employer or insurance carrier shall pay for interpreter services. An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.

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

§ 4600.05. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) An employer, as defined in Section 3300, shall provide immediate support from a nurse case manager for employees injured by an act of domestic terrorism, as defined in Section 2331 of Title 18 of the United States Code, whose injuries arise out of and in the course of employment, to assist injured employees in obtaining medically necessary medical treatment, as defined by the medical treatment utilization schedule adopted pursuant to Section 5307.27, and to assist providers of medical services in seeking authorization of medical treatment.

(b) (1) This section shall apply only if the Governor has declared a state of emergency pursuant to subdivision (b) of Section 8558 of the Government Code in connection with the act of domestic terrorism.

(2) Upon the issuance of a declaration pursuant to paragraph (1), an employer that has been notified of a claim for compensation arising out of the acts that resulted in the declaration shall provide a notice within three days to the claimant advising the claimant of medically necessary services provided pursuant to subdivision (a). In the case of a claim for compensation subject to this section that is filed after the declaration, the employer shall provide the notice to the claimant within three days. The notice shall be in the form adopted by the administrative director pursuant to subdivision (d).

(c) This section shall not alter the conditions for compensability of an injury, as described in Sections 3208.3 and 3600.

(d) The administrative director shall adopt regulations to implement this section, including, but not limited to, the definition of a nurse case manager's qualifications, the scope and timing of immediate support from a nurse case manager, and the contents of the notice that employers shall provide to claimants.

§ 4600.1. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) Subject to subdivision (b), any person or entity that dispenses medicines and medical supplies, as required by Section 4600, shall dispense the generic drug equivalent.

(b) A person or entity is not required to dispense a generic drug equivalent under either of the following circumstances:

(1) When a generic drug equivalent is unavailable.

(2) When the prescribing physician specifically provides in writing that a nongeneric drug must be dispensed.

(c) For purposes of this section, "dispense" has the same meaning as the definition contained in Section 4024 of the Business and Professions Code.

(d) Nothing in this section shall be construed to preclude a prescribing physician, who is also the dispensing physician, from dispensing a generic drug equivalent.

(e) This section shall only apply to medicines dispensed prior to the operative date of the drug formulary adopted pursuant to Section 5307.27.

§ 4600.2. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) Notwithstanding Section 4600, if a self-insured employer, group of self-insured employers, insurer of an employer, or group of insurers contracts with a pharmacy, group of pharmacies, or pharmacy benefit network to provide medicines and medical supplies required by this article to be provided to injured employees, those injured employees that are subject to the contract shall be provided medicines and medical supplies in the manner prescribed in the contract for as long as medicines or medical supplies are reasonably required to cure or relieve the injured employee from the effects of the injury. Medicines provided pursuant to the contract shall be subject to the drug formulary adopted by the administrative director pursuant to Section 5307.27, and such contracts may not limit the availability of medications otherwise prescribed pursuant to the formulary based on whether the pharmacy services are provided within or outside a medical provider network.

(b) Nothing in this section shall affect the ability of employee-selected physicians to continue to prescribe and have the employer provide medicines subject to the drug formulary and medical supplies that the physicians deem reasonably required to cure or relieve the injured employee from the effects of the injury.

(c) Each contract described in subdivision (a) shall comply with standards adopted by the administrative director. In adopting those standards, the administrative director shall seek to reduce pharmaceutical costs and may consult any relevant studies or practices in other states. The standards shall provide for access to a pharmacy within a reasonable geographic distance from an injured employee's residence.

§ 4600.3. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

1215 of the Insurance Code, this information shall be included in the notice of contract with a health care organization.

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

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

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

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

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

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

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

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

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

(g) Notwithstanding subdivision (c), in the event that the employer, group of employers, or the employer's workers' compensation insurer no longer contracts with the health care organization that has been treating an injured employee, the employee may continue treatment provided or arranged by the health care organization. If the employee does not choose to continue treatment by the health care organization, the employer may control the employee's treatment for 30 days from the date the injury was reported. After that period, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area.

§ 4600.35. Workers' Compensation and Insurance -- Medical and Hospital Treatment

Any entity seeking to reimburse health care providers for health care services rendered to injured workers on a capitated, or per person per month basis, shall be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

§ 4600.4. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) A workers' compensation insurer, third-party administrator, or other entity that requires, or pursuant to regulation requires, a treating physician to obtain either utilization review or prior authorization in order to diagnose or treat injuries or diseases compensable under this article, shall ensure the availability of those services from 9 a.m. to 5:30 p.m. Pacific coast time of each normal business day.

(b) For purposes of this section "normal business day" means a business day as defined in Section 9 of the Civil Code.

§ 4600.5. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

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

(c) If the health care organization is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, and has provided the Managed Care Unit of the Division of Workers' Compensation with the necessary documentation to comply with this subdivision, that organization shall be deemed to be a health care organization able to provide health care pursuant to Section 4600.3, without further application duplicating the documentation already filed with the Department of Managed Health Care. These plans shall be required to remain in good standing with the Department of Managed Health Care, and shall meet the following additional requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Complies with the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

work-related injuries that are within the guidelines for acupuncture care established by paragraph (2). Acupuncture care rendered in accordance with guidelines for acupuncture care established pursuant to paragraph (2) shall be provided by duly licensed acupuncturists affiliated with the plan.

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

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

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

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

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

§ 4600.6. Workers' Compensation and Insurance -- Medical and Hospital Treatment

Any workers' compensation insurer, third-party administrator, or other entity seeking certification as a health care organization under subdivision (e) of Section 4600.5 shall be subject to the following rules and procedures:

(a) Each application for authorization as an organization under subdivision (e) of Section 4600.5 shall be verified by an authorized representative of the applicant and shall be in a form prescribed by the administrative director. The application shall be accompanied by the prescribed fee and shall set forth or be accompanied by each and all of the following:

(1) The basic organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto.

(2) A copy of the bylaws, rules, and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, which shall include, among others, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal

officers, each shareholder with over 5 percent interest in the case of a corporation, and all partners or members in the case of a partnership or association, and each person who has loaned funds to the applicant for the operation of its business.

(4) A copy of any contract made, or to be made, between the applicant and any provider of health care, or persons listed in paragraph (3), or any other person or organization agreeing to perform an administrative function or service for the plan. The administrative director by rule may identify contracts excluded from this requirement and make provision for the submission of form contracts. The payment rendered or to be rendered to the provider of health care services shall be deemed confidential information that shall not be divulged by the administrative director, except that the payment may be disclosed and become a public record in any legislative, administrative, or judicial proceeding or inquiry. The organization shall also submit the name and address of each provider employed by, or contracting with, the organization, together with his or her license number.

(5) A statement describing the organization, its method of providing for health services, and its physical facilities. If applicable, this statement shall include the health care delivery capabilities of the organization, including the number of full-time and part-time physicians under Section 3209.3, the numbers and types of licensed or state-certified health care support staff, the number of hospital beds contracted for, and the arrangements and the methods by which health care will be provided, as defined by the administrative director under Sections 4600.3 and 4600.5.

(6) A copy of the disclosure forms or materials that are to be issued to employees.

(7) A copy of the form of the contract that is to be issued to any employer, insurer of an employer, or a group of self-insured employers.

(8) Financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant. However, the financial statements from public entities or political subdivisions of the state need not include a report, certificate, or opinion by an independent certified public accountant if the financial statement complies with any requirements that may be established by regulation of the administrative director.

(9) A description of the proposed method of marketing the organization and a copy of any contract made with any person to solicit on behalf of the organization or a copy of the form of agreement used and a list of the contracting parties.

(10) A statement describing the service area or areas to be served, including the service location for each provider rendering professional services on behalf of the organization and the location of any other organization facilities where required by the administrative director.

(11) A description of organization grievance procedures to be utilized as required by this part, and a copy of the form specified by paragraph (3) of subdivision (j).

(12) A description of the procedures and programs for internal review of the quality of health care pursuant to the requirements set forth in this part.

(13) Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of the furnishing of workers' compensation health care.

(14) Evidence of adequate insurance coverage or self-insurance to protect against losses of facilities where required by the administrative director.

(15) Evidence of adequate workers' compensation coverage to protect against claims arising out of work-related injuries that might be brought by the employees and staff of an organization against the organization.

(16) Evidence of fidelity bonds in such amount as the administrative director prescribes by regulation.

(17) Other information that the administrative director may reasonably require.

(b) (1) An organization, solicitor, solicitor firm, or representative may not use or permit the use of any advertising or solicitation that is untrue or misleading, or any form of disclosure that is deceptive. For purposes of this chapter:

(A) A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect that is or may be significant to an employer or employee, or potential employer or employee.

(B) A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an employer or employee, or potential employer or employee.

(C) A disclosure form shall be deemed to be deceptive if the disclosure form taken as a whole and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge of workers' compensation health care, and the disclosure form therefor, to expect benefits, service charges, or other advantages that the disclosure form does not provide or that the organization issuing that disclosure form does not regularly make available to employees.

(2) An organization, solicitor, or representative may not use or permit the use of any verbal statement that is untrue, misleading, or deceptive or make any representations about health care offered by the organization or its cost that does not conform to fact. All verbal statements are to be held to the same standards as those for printed matter provided in paragraph (1).

(c) It is unlawful for any person, including an organization, subject to this part, to represent or imply in any manner that the person or organization has been sponsored, recommended, or approved, or that the person's or organization's abilities or qualifications have in any respect been passed upon, by the administrative director.

(d) (1) An organization may not publish or distribute, or allow to be published or distributed on its behalf, any advertisement unless (A) a true copy thereof has first been filed with the administrative director, at least 30 days prior to any such use, or any shorter period as the administrative director by rule or order may allow, and (B) the administrative director by notice has not found the advertisement, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this part or the rules thereunder, and specified the deficiencies, within the 30 days or any shorter time as the administrative director by rule or order may allow.

(2) If the administrative director finds that any advertisement of an organization has materially failed to comply with this part or the rules thereunder, the administrative director may, by order, require the

organization to publish in the same or similar medium, an approved correction or retraction of any untrue, misleading, or deceptive statement contained in the advertising.

(3) The administrative director by rule or order may classify organizations and advertisements and exempt certain classes, wholly or in part, either unconditionally or upon specified terms and conditions or for specified periods, from the application of subdivision (a).

(e) (1) The administrative director shall require the use by each organization of disclosure forms or materials containing any information regarding the health care and terms of the workers' compensation health care contract that the administrative director may require, so as to afford the public, employers, and employees with a full and fair disclosure of the provisions of the contract in readily understood language and in a clearly organized manner. The administrative director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between contracts of the same or other types of organizations. The disclosure form shall describe the health care that is required by the administrative director under Sections 4600.3 and 4600.5, and shall provide that all information be in concise and specific terms, relative to the contract, together with any additional information as may be required by the administrative director, in connection with the organization or contract.

(2) All organizations, solicitors, and representatives of a workers' compensation health care provider organization shall, when presenting any contract for examination or sale to a prospective employee, provide the employee with a properly completed disclosure form, as prescribed by the administrative director pursuant to this section for each contract so examined or sold.

(3) In addition to the other disclosures required by this section, every organization and any agent or employee of the organization shall, when representing an organization for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium cost to health care paid for contracts with individuals and with groups of the same or similar size for the organization's preceding fiscal year. An organization may report that information by geographic area, provided the organization identifies the geographic area and reports information applicable to that geographic area.

(4) Where the administrative director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by an organization for the purpose of influencing persons to become members of an organization shall contain any supplemental disclosure information that the administrative director may require.

(f) When the administrative director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by an organization for the purpose of influencing persons to become members of an organization shall contain any supplemental disclosure information that the administrative director may require.

(g) (1) An organization may not refuse to enter into any contract, or may not cancel or decline to renew or reinstate any contract, because of the age or any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as an employee or otherwise.

(2) The terms of any contract shall not be modified, and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions, copayments, coinsurance, deductibles, reservations, or premium, price, or charge differentials, or other modifications because of the age or any

characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code of any contracting party, potential contracting party, or person reasonably expected to benefit from that contract as an employee or otherwise; except that premium, price, or charge differentials because of the sex or age of any individual when based on objective, valid, and up-to-date statistical and actuarial data are not prohibited. Nothing in this section shall be construed to permit an organization to charge different rates to individual employees within the same group solely on the basis of the employee's sex.

(3) It shall be deemed a violation of subdivision (a) for any organization to utilize marital status, living arrangements, occupation, gender, beneficiary designation, ZIP Codes or other territorial classification, or any combination thereof for the purpose of establishing sexual orientation. Nothing in this section shall be construed to alter in any manner the existing law prohibiting organizations from conducting tests for the presence of human immunodeficiency virus or evidence thereof.

(4) This section shall not be construed to limit the authority of the administrative director to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.

(h) (1) An organization may not use in its name any of the words "insurance," "casualty," "health care service plan," "health plan," "surety," "mutual," or any other words descriptive of the health plan, insurance, casualty, or surety business or use any name similar to the name or description of any health care service plan, insurance, or surety corporation doing business in this state unless that organization controls or is controlled by an entity licensed as a health care service plan or insurer pursuant to the Health and Safety Code or the Insurance Code and the organization employs a name related to that of the controlled or controlling entity.

(2) Section 2415 of the Business and Professions Code, pertaining to fictitious names, does not apply to organizations certified under this section.

(3) An organization or solicitor firm may not adopt a name style that is deceptive, or one that could cause the public to believe the organization is affiliated with or recommended by any governmental or private entity unless this affiliation or endorsement exists.

(i) Each organization shall meet the following requirements:

(1) All facilities located in this state, including, but not limited to, clinics, hospitals, and skilled nursing facilities, to be utilized by the organization shall be licensed by the State Department of Health Services, if that licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(2) All personnel employed by or under contract to the organization shall be licensed or certified by their respective board or agency, where that licensure or certification is required by law.

(3) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for that equipment shall be licensed or certified as required by law.

(4) The organization shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at any time as may be appropriate and consistent with good professional practice.

(5) All health care shall be readily available at reasonable times to all employees. To the extent feasible, the organization shall make all health care readily accessible to all employees.

(6) The organization shall employ and utilize allied health manpower for the furnishing of health care to the extent permitted by law and consistent with good health care practice.

(7) The organization shall have the organizational and administrative capacity to provide services to employees. The organization shall be able to demonstrate to the department that health care decisions are rendered by qualified providers, unhindered by fiscal and administrative management.

(8) All contracts with employers, insurers of employers, and self-insured employers and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the workers' compensation health care organization, shall be fair, reasonable, and consistent with the objectives of this part.

(9) Each organization shall provide to employees all workers' compensation health care required by this code. The administrative director shall not determine the scope of workers' compensation health care to be offered by an organization.

(j) (1) Every organization shall establish and maintain a grievance system approved by the administrative director under which employees may submit their grievances to the organization. Each system shall provide reasonable procedures in accordance with regulations adopted by the administrative director that shall ensure adequate consideration of employee grievances and rectification when appropriate.

(2) Every organization shall inform employees upon enrollment and annually thereafter of the procedures for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Every organization shall provide forms for complaints to be given to employees who wish to register written complaints. The forms used by organizations shall be approved by the administrative director in advance as to format.

(4) The organization shall keep in its files all copies of complaints, and the responses thereto, for a period of five years.

(k) Every organization shall establish procedures in accordance with regulations of the administrative director for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in quality of care or utilization reviews by peer review committees that are composed chiefly of physicians, as defined by Section 3209.3, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of an organization or to any person or entity designated by the organization to review activities of the committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony does not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the administrative director in conducting surveys pursuant to subdivision (o).

This section shall not be construed to confer immunity from liability on any workers' compensation health care organization. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against an organization, the cause of action shall exist notwithstanding the provisions of this section.

(l) Nothing in this chapter shall be construed to prevent an organization from utilizing subcommittees to participate in peer review activities, nor to prevent an organization from delegating the responsibilities required by subdivision (i) as it determines to be appropriate, to subcommittees including subcommittees composed of a majority of nonphysician health care providers licensed pursuant to the Business and Professions Code, as long as the organization controls the scope of authority delegated and may revoke all or part of this authority at any time. Persons who participate in the subcommittees shall be entitled to the same immunity from monetary liability and actions for civil damages as persons who participate in organization or provider peer review committees pursuant to subdivision (i).

(m) Every organization shall have and shall demonstrate to the administrative director that it has all of the following:

(1) Adequate provision for continuity of care.

(2) A procedure for prompt payment and denial of provider claims.

(n) Every contract between an organization and an employer or insurer of an employer, and every contract between any organization and a provider of health care, shall be in writing.

(o) (1) The administrative director shall conduct periodically an onsite medical survey of the health care delivery system of each organization. The survey shall include a review of the procedures for obtaining health care, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the organization in providing health care and meeting the health needs of employees.

(2) The survey shall be conducted by a panel of qualified health professionals experienced in evaluating the delivery of workers' compensation health care. The administrative director shall be authorized to contract with professional organizations or outside personnel to conduct medical surveys. These organizations or personnel shall have demonstrated the ability to objectively evaluate the delivery of this health care.

(3) Surveys performed pursuant to this section shall be conducted as often as deemed necessary by the administrative director to assure the protection of employees, but not less frequently than once every three years. Nothing in this section shall be construed to require the survey team to visit each clinic, hospital, office, or facility of the organization.

(4) Nothing in this section shall be construed to require the medical survey team to review peer review proceedings and records conducted and compiled under this section or in medical records. However, the administrative director shall be authorized to require onsite review of these peer review proceedings and records or medical records where necessary to determine that quality health care is being delivered to employees. Where medical record review is authorized, the survey team shall ensure that the confidentiality of the physician-patient relationship is safeguarded in accordance with existing law and neither the survey team nor the administrative director or the administrative director's staff may be compelled to disclose this information except in accordance with the physician-patient relationship. The administrative director shall ensure that the confidentiality of the peer review proceedings and records is maintained. The disclosure of the

peer review proceedings and records to the administrative director or the medical survey team shall not alter the status of the proceedings or records as privileged and confidential communications.

(5) The procedures and standards utilized by the survey team shall be made available to the organizations prior to the conducting of medical surveys.

(6) During the survey, the members of the survey team shall offer such advice and assistance to the organization as deemed appropriate.

(7) The administrative director shall notify the organization of deficiencies found by the survey team. The administrative director shall give the organization a reasonable time to correct the deficiencies, and failure on the part of the organization to comply to the administrative director's satisfaction shall constitute cause for disciplinary action against the organization.

(8) Reports of all surveys, deficiencies, and correction plans shall be open to public inspection, except that no surveys, deficiencies or correction plans shall be made public unless the organization has had an opportunity to review the survey and file a statement of response within 30 days, to be attached to the report.

(p) (1) All records, books, and papers of an organization, management company, solicitor, solicitor firm, and any provider or subcontractor providing medical or other services to an organization, management company, solicitor, or solicitor firm shall be open to inspection during normal business hours by the administrative director.

(2) To the extent feasible, all the records, books, and papers described in paragraph (1) shall be located in this state. In examining those records outside this state, the administrative director shall consider the cost to the organization, consistent with the effectiveness of the administrative director's examination, and may upon reasonable notice require that these records, books, and papers, or a specified portion thereof, be made available for examination in this state, or that a true and accurate copy of these records, books, and papers, or a specified portion thereof, be furnished to the administrative director.

(q) (1) The administrative director shall conduct an examination of the administrative affairs of any organization, and each person with whom the organization has made arrangements for administrative, or management services, as often as deemed necessary to protect the interest of employees, but not less frequently than once every five years.

(2) The expense of conducting any additional or nonroutine examinations pursuant to this section, and the expense of conducting any additional or nonroutine medical surveys pursuant to subdivision (o) shall be charged against the organization being examined or surveyed. The amount shall include the actual salaries or compensation paid to the persons making the examination or survey, the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the administrative director. In determining the cost of examinations or surveys, the administrative director may use the estimated average hourly cost for all persons performing examinations or surveys of workers' compensation health care organizations for the fiscal year. The amount charged shall be remitted by the organization to the administrative director.

(3) Reports of all examinations shall be open to public inspection, except that no examination shall be made public, unless the organization has had an opportunity to review the examination report and file a statement or response within 30 days, to be attached to the report.

§ 4600.7. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) The Workers' Compensation Managed Care Fund is hereby created in the State Treasury for the administration of Sections 4600.3 and 4600.5 by the Division of Workers' Compensation. The administrative director shall establish a schedule of fees and revenues to be charged to certified health care organizations and applicants for certification to fully fund the administration of these provisions and to repay amounts received as a loan from the General Fund. All fees and revenues shall be deposited in the Workers' Compensation Managed Care Fund and shall be used when appropriated by the Legislature solely for the purpose of carrying out the responsibilities of the Division of Workers' Compensation under Section 4600.3 or 4600.5.

(b) On and after July 1, 1998, no funds received as a loan from the General Fund shall be used to support the administration of Sections 4600.3 and 4600.5. The loan amount shall be repaid to the General Fund by assessing a surcharge on the enrollment fee for each of the next five fiscal years. In the event the surcharge does not produce sufficient revenue over this period, the surcharge shall be adjusted to fully repay the loan over the following three fiscal years, with the final assessment calculated by dividing the balance of the loan by the enrollees at the end of the final fiscal year.

§ 4601. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

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

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

§ 4602. Workers' Compensation and Insurance -- Medical and Hospital Treatment

If the employee so requests, the employer shall procure certification by either the administrative director or the appeals board as the case may be of the competency, for the particular case, of the consulting or additional physicians.

§ 4603. Workers' Compensation and Insurance -- Medical and Hospital Treatment

If the employer desires a change of physicians or chiropractor, he may petition the administrative director who, upon a showing of good cause by the employer, may order the employer to provide a panel of five physicians, or if requested by the employee, four physicians and one chiropractor competent to treat the particular case, from which the employee must select one.

§ 4603.2. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

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

(3) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was not entitled to select a physician outside of the medical provider network, the employer is not liable for treatment provided by or at the direction of that physician or for any consequences of the treatment obtained outside the network.

(b) (1) (A) A provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received. This section does not prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an

alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600.

(B) Effective for services provided on or after January 1, 2017, the request for payment with an itemization of services provided and the charge for each service shall be submitted to the employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services. The administrative director shall adopt rules to implement the 12-month limitation period. The rules shall define circumstances that constitute good cause for an exception to the 12-month period, including provisions to address the circumstances of a nonoccupational injury or illness later found to be a compensable injury or illness. The request for payment is barred unless timely submitted.

(C) Notwithstanding the requirements of this paragraph, a copy of the prescription shall not be required with a request for payment for pharmacy services, unless the provider of services has entered into a written agreement, as provided in this paragraph, that requires a copy of a prescription for a pharmacy service.

(D) This section does not preclude an employer, insurer, pharmacy benefits manager, or third-party claims administrator from requesting a copy of the prescription during a review of any records of prescription drugs that were dispensed by a pharmacy.

(2) Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service. Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer. An explanation of review that states an itemization is incomplete shall also state all additional information required to make a decision. A properly documented list of services provided and not paid at the rates then in effect under Section 5307.1 within the 45-day period shall be paid at the rates then in effect and increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization, unless the employer does both of the following:

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

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

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

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

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

(5) (A) An employer may defer objecting to or paying any bill submitted by, or on behalf of, a provider whose liens are stayed pursuant to Section 4615, and the time limits for taking any action prescribed by paragraphs (2) and (3) shall not commence until the stay is lifted pursuant to Section 4615.

(B) An employer may object to any bill submitted by, or on behalf of, a provider who has been suspended pursuant to Section 139.21.

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

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

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

(e) (1) If the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review pursuant to paragraph (5) of subdivision (a) of Section 4603.3. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and shall include all of the following:

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

(B) The item and amount in dispute.

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

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

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

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

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

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

§ 4603.3. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

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

(2) The amount paid.

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

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

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

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

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

§ 4603.4. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

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

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

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

(4) Require the timely submission of paper or electronic bills in conformity with subparagraph (B) of paragraph (1) of subdivision (b) of Section 4603.2.

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

(c) Require all employers to accept electronic claims for payment of medical services.

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

§ 4603.5. Workers' Compensation and Insurance -- Medical and Hospital Treatment

The administrative director shall adopt rules pertaining to the format and content of notices required by this article; define reasonable geographic areas for the purposes of Section 4600; specify time limits for all such notices, and responses thereto; and adopt any other rules necessary to make effective the requirements of this article.

Employers shall notify all employees of their rights under this section.

§ 4603.6. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

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

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

(d) Upon receipt of a request for independent bill review and the required fee, the administrative director or the administrative director's designee shall assign the request to an independent bill reviewer within 30 days and notify the medical provider and employer of the independent reviewer assigned.

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

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

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

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

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

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

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

(g) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent bill review by a different independent review organization. In the event that a different independent bill review organization is not available after remand, the administrative director shall submit the dispute to the original bill review organization for review by a

different reviewer within the organization. In no event shall the appeals board or any higher court make a determination of ultimate fact contrary to the determination of the bill review organization.

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

§ 4604. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

§ 4604.5. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence and scientifically based, nationally recognized, and peer reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

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

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

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

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

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

§ 4605. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

§ 4606. Workers' Compensation and Insurance -- Medical and Hospital Treatment

Any county, city and county, city, school district, or other public corporation within the state which was a self-insured employer under the "Workmen's Compensation, Insurance and Safety Act," enacted by Chapter 176 of the Statutes of 1913, may provide such medical, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including artificial members, which is reasonably required to cure or relieve from the effects of an injury to a former employee who was covered under such act, without regard to the 90-day limitation of subdivision (a) of Section 15 of such act for medical treatment. The provisions of this section shall not be operative in any such county, city and county, city, school district, or other public corporation unless adopted by a resolution of the governing body of such public entity.

§ 4607. Workers' Compensation and Insurance -- Medical and Hospital Treatment

Where a party to a proceeding institutes proceedings to terminate an award made by the appeals board to an applicant for continuing medical treatment and is unsuccessful in such proceedings, the appeals board may determine the amount of attorney's fees reasonably incurred by the applicant in resisting the proceeding to terminate the medical treatment, and may assess such reasonable attorney's fees as a cost upon the party instituting the proceedings to terminate the award of the appeals board.

§ 4608. Workers' Compensation and Insurance -- Medical and Hospital Treatment

No workers' compensation insurer, self-insured employer, or agent of an insurer or self-insured employer, shall refuse to pay pharmacy benefits solely because the claim form utilized is reproduced by the person providing the pharmacy benefits, provided the reproduced form is an exact copy of that used by the insurer, self-insured employer, or agent.

§ 4609. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in any payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed by the contracting agent to the provider in advance and shall actively encourage employees to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage employees to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged employees to use the list of contracted providers if the employer provides information directly to employees during the period the employer has medical control advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to employees; or in advance of a workplace injury, or upon notice of an injury or claim by an employee, the approaches may include, but are not limited to, the use of provider directories, the use of a list of all contracted providers in an area geographically accessible to the posting site, the use of wall cards that direct employees to a readily accessible listing of those providers at the same location as the wall cards, the use of wall cards that direct employees to a toll-free telephone number or Internet Web site address, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly during the period the employer has medical control. However, Internet Web site addresses alone shall not be deemed to satisfy the requirements of this paragraph. Nothing in this paragraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of an employee. A payor who otherwise meets the requirements of this paragraph is deemed to have met the requirements of this paragraph regardless of the employer's ability to control medical treatment pursuant to Sections 4600 and 4600.3.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the employees to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the employees to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 15 business days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreements with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the employees to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and any other contracting agent that buys, leases, or otherwise obtains the list of contracted providers.

A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the employees to use the list of contracted providers when

obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the employees to use the list of contracted providers when obtaining medical care.

(6) If the payor's explanation of benefits or explanation of review does not identify the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered, the contracting agent shall do the following:

(A) Maintain a Web site that is accessible to all contracted providers and updated at least quarterly and maintain a toll-free telephone number accessible to all contracted providers whereby providers may access payor summary information.

(B) Disclose through the use of an Internet Web site, a toll-free telephone number, or through a delivery or mail service to its contracted providers, within 30 days, any sale, lease assignment, transfer or conveyance of the contracted reimbursement rates to another contracting agent or payor.

(7) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the network with which the payor has an agreement that entitles them to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The provider shall include in the request a statement explaining why the payment is not at the correct contracted rate for the services provided. The failure of the provider to include a statement shall relieve the payor from the responsibility of demonstrating that it is entitled to pay the disputed contracted rate. The failure of a payor to make the demonstration to a properly documented request of the provider within 30 business days shall render the payor responsible for the lesser of the provider's actual fee or, as applicable, any fee schedule pursuant to this division, which amount shall be due and payable within 10 days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this subdivision. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(A) Describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b), and demonstrates compliance with paragraph (1).

(B) Identifies the contracting agent with whom the payor has a written agreement whereby the payor is not required to actively encourage employees to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Contracting agent" means an insurer licensed under the Insurance Code to provide workers' compensation insurance, a health care service plan, including a specialized health care service plan, a preferred provider organization, or a self-insured employer, while engaged, for monetary or other

consideration, in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide health care services to employees for work-related injuries.

(2) "Employee" means a person entitled to seek health care services for a work-related injury.

(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of subdivision (c), "payor" means an insurer licensed under the Insurance Code to provide workers' compensation insurance, a self-insured employer, a third-party administrator or trust, or any other third party that is responsible to pay health care services provided to employees for work-related injuries, or an agent of an entity included in this definition.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(e) This section shall become operative on July 1, 2000.

§ 4610. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

(b) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee

is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

(1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.

(2) Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.

(3) Psychological treatment services.

(4) Home health care services.

(5) Imaging and radiology services, excluding X-rays.

(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.

(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.

(8) Any other service designated and defined through rules adopted by the administrative director.

(d) (1) Except for emergency treatment services, any request for payment for treatment provided under subdivision (b) shall comply with Section 4603.2 and be submitted to the employer, or its insurer or claims administrator, within 30 days of the date the service was provided.

(2) (A) In the case of emergency treatment services, any request for payment for treatment provided under subdivision (b) shall comply with Section 4603.2 and be submitted to the employer, or its insurer or claims administrator, within 180 days of the date the service was provided.

(B) For the purposes of this subdivision, "emergency treatment services" means treatment for an emergency medical condition defined in subdivision (b) of Section 1317.1 of the Health and Safety Code and provided in a licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code.

(e) If a physician fails to submit the report required under Section 6409 and a complete request for authorization, as described in subdivision (b), an employer may remove the physician's ability under this subdivision to provide further medical treatment to the employee that is exempt from prospective utilization review.

(f) An employer may perform retrospective utilization review for any treatment provided pursuant to subdivision (b) solely for the purpose of determining if the physician is prescribing treatment consistent with

the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Section 5307.27.

(1) If it is found after retrospective utilization reviews that there is a pattern and practice of the physician or provider failing to render treatment consistent with the schedule for medical treatment utilization, including the drug formulary, the employer may remove the ability of the predesignated physician, employer-selected physician, or the member of the medical provider network or health care organization under this subdivision to provide further medical treatment to any employee that is exempt from prospective utilization review. The employer shall notify the physician or provider of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.

(2) The results of retrospective utilization review may constitute a showing of good cause for an employer's petition requesting a change of physician or provider pursuant to Section 4603 and may serve as grounds for termination of the physician or provider from the medical provider network or health care organization.

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

(1) Each utilization review process that modifies or denies requests for authorization of medical treatment shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

(2) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(3) (A) A person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, if these services are within the scope of the physician's practice, requested by the physician, shall not modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve or due to incomplete or insufficient information under subdivisions (i) and (j).

(B) (i) The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.

(ii) An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party administrator provides the employer and the administrative director with prior written disclosure of both of the following:

(I) The entity conducting the utilization review services.

(II) The insurer or third-party administrator's financial interest in the entity.

(C) The administrative director has authority pursuant to this section to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician. Any information disclosed to the administrative director pursuant to this paragraph shall be considered confidential information and not subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Disclosure of the information to the administrative director pursuant to this subdivision shall not waive the provisions of the Evidence Code relating to privilege.

(4) A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review services, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

(A) Require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation.

(B) Exempt nonprofit, public sector internal utilization review programs from the accreditation requirement pursuant to this section, if the administrative director has adopted minimum standards applicable to nonprofit, public sector internal utilization review programs that meet or exceed the accreditation standards developed pursuant to this section.

(5) On or before July 1, 2018, each employer, either directly or through its insurer or an entity with which an employer or insurer contracts for utilization review services, shall submit a description of the utilization review process that modifies or denies requests for authorization of medical treatment and the written policies and procedures to the administrative director for approval. Approved utilization review process descriptions and the accompanying written policies and procedures shall be disclosed by the employer to employees and physicians and made available to the public by posting on the employer's, claims administrator's, or utilization review organization's Internet Web site.

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

(1) Developed with involvement from actively practicing physicians.

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

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

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

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. A charge shall not be required for an employee whose physician's request for medical treatment services is under review.

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

(1) Except for treatment requests made pursuant to the formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request. The request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director.

(2) In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of the information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(3) If the employee's condition is one in which the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(4) (A) Final decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure email.

(B) Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated in writing to the employee, and to the physician if the initial communication under subparagraph (A) was by telephone, within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is modified or denied, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(C) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. A compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in a way that minimizes reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. Fees shall not be levied upon insurers or self-insured employers making reports required by this section.

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

(A) The reason for the decision.

(B) A specific description of the information that is needed.

(C) The date(s) and time(s) of attempts made to contact the physician to obtain the necessary information.

(D) A description of the manner in which the request was communicated.

(j) (1) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, that employer, insurer, or other entity shall request only the information reasonably necessary to make the determination.

(2) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i) because the employer or other entity is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information that must be provided by the physician for a determination to be made. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i).

(k) A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further

recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

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

(m) If utilization review is deferred pursuant to subdivision (l), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (2) of subdivision (i) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(n) Each employer, insurer, or other entity subject to this section shall maintain telephone access during California business hours for physicians to request authorization for health care services and to conduct peer-to-peer discussions regarding issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity decision.

(o) The administrative director shall develop a system for the mandatory electronic reporting of documents related to every utilization review performed by each employer, which shall be administered by the Division of Workers' Compensation. The administrative director shall adopt regulations specifying the documents to be submitted by the employer and the authorized transmission format and timeframe for their submission. For purposes of this subdivision, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

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

(q) The administrative director shall contract with an outside, independent research organization on or after March 1, 2019, to evaluate the impact of the provision of medical treatment within the first 30 days after a claim is filed, for a claim filed on or after January 1, 2017, and before January 1, 2019. The report shall be provided to the administrative director, the Senate Committee on Labor and Industrial Relations, and the Assembly Committee on Insurance before January 1, 2020.

(r) This section shall become operative on January 1, 2018.

§ 4610.1. Workers' Compensation and Insurance -- Medical and Hospital Treatment

An employee shall not be entitled to an increase in compensation under Section 5814 for unreasonable delay in the provision of medical treatment for periods of time necessary to complete the utilization review process in compliance with Section 4610. A determination by the appeals board or a final determination of the

administrative director pursuant to independent medical review that medical treatment is appropriate shall not be conclusive evidence that medical treatment was unreasonably delayed or denied for purposes of penalties under Section 5814. In no case shall this section preclude an employee from entitlement to an increase in compensation under Section 5814 when an employer has unreasonably delayed or denied medical treatment due to an unreasonable delay in completion of the utilization review process set forth in Section 4610.

§ 4610.3. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) Regardless of whether an employer has established a medical provider network pursuant to Section 4616 or entered into a contract with a health care organization pursuant to Section 4600.5, an employer that authorizes medical treatment shall not rescind or modify that authorization after the medical treatment has been provided based on that authorization for any reason, including, but not limited to, the employer's subsequent determination that the physician who treated the employee was not eligible to treat that injured employee. If the authorized medical treatment consists of a series of treatments or services, the employer may rescind or modify the authorization only for the treatments or services that have not already been provided.

(b) This section shall not be construed to expand or alter the benefits available under, or the terms and conditions of, any contract, including, but not limited to, existing medical provider network and health care organization contracts.

(c) This section shall not be construed to impact the ability of the employer to transfer treatment of an injured employee into a medical provider network or health care organization. This subdivision is declaratory of existing law.

(d) This section shall not be construed to establish that a provider of authorized medical treatment is the physician primarily responsible for managing the injured employee's care for purposes of rendering opinions on all medical issues necessary to determine eligibility for compensation.

§ 4610.5. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) This section applies to the following disputes:

(1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.

(2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(3) Any dispute occurring on or after January 1, 2018, over medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

(b) A dispute described in subdivision (a) shall be resolved only in accordance with this section.

(c) For purposes of this section and Section 4610.6, the following definitions apply:

(1) "Disputed medical treatment" means medical treatment that has been modified or denied by a utilization review decision on the basis of medical necessity.

(2) “Medically necessary” and “medical necessity” mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied as set forth in the medical treatment utilization schedule, including the drug formulary, adopted by the administrative director pursuant to Section 5307.27:

(A) The guidelines, including the drug formulary, adopted by the administrative director pursuant to Section 5307.27.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(3) “Utilization review decision” means a decision pursuant to Section 4610 to modify or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402. “Utilization review decision” may also mean a determination, occurring on or after January 1, 2018, by a physician regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

(4) Unless otherwise indicated by context, “employer” means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

(d) If a utilization review decision denies or modifies a treatment recommendation based on medical necessity, the employee may request an independent medical review as provided by this section.

(e) A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is modified or denied by a utilization review decision, unless the utilization review decision is overturned by independent medical review in accordance with this section.

(f) As part of its notification to the employee regarding an initial utilization review decision based on medical necessity that denies or modifies a treatment recommendation, the employer shall provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative director’s designee to initiate an independent medical review. The employee may also request independent medical review electronically under rules adopted by the administrative director. The employer shall include on the form any information required by the administrative director to facilitate the completion of the independent medical review. The form shall also include all of the following:

(1) Notice that the utilization review decision is final unless the employee requests independent medical review.

(2) A statement indicating the employee's consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter, to be signed by the employee.

(3) Notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding the following:

(A) The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.

(B) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.

(C) Reasonable information supporting the employee's position that the disputed medical treatment is or was medically necessary for the employee's medical condition, including all information provided to the employee by the employer or by the treating physician, still in the employee's possession, concerning the employer's or the physician's decision regarding the disputed medical treatment, as well as any additional material that the employee believes is relevant.

(g) The independent medical review process may be terminated at any time upon the employer's written authorization of the disputed medical treatment. Notice of the authorization, any settlement or award that may resolve the medical treatment dispute, or the requesting physician withdrawing the request for treatment, shall be communicated to the independent medical review organization by the employer within five days.

(h) (1) The employee may submit a request for independent medical review to the division. The request may be made electronically under rules adopted by the administrative director. The request shall be made no later than as follows:

(A) For formulary disputes, 10 days after the service of the utilization review decision to the employee.

(B) For all other medical treatment disputes, 30 days after the service of the utilization review decision to the employee.

(2) If at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(3) If the employer fails to comply with subdivision (f) at the time of notification of its utilization review decision, the time limitations for the employee to submit a request for independent medical review shall not begin to run until the employer provides the required notice to the employee.

(4) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf. A request submitted by a provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.

(i) An employer shall not engage in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the employer to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars ($5,000) for each day that proper notification to the employee is delayed. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(j) For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee.

(k) The administrative director or his or her designee shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the employer agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.

(l) Upon notice from the administrative director that an independent review organization has been assigned, the employer shall electronically provide to the independent medical review organization under rules adopted by the administrative director a copy and list of all of the following documents within 10 days of notice of assignment:

(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following:

(A) The employee's current medical condition.

(B) The medical treatment being provided by the employer.

(C) The request for authorization and utilization review decision.

(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.

(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for the disputed treatment.

(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to deny or modify the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.

(m) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a copy of medical records required by this subdivision to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

(n) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents required by subdivision (l) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

(o) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee.

(p) The claims administrator who issued the utilization review decision in dispute shall notify the independent medical review organization if there is a change in the claims administrator responsible for the claim. Notice shall be given to the independent medical review organization within five working days of the change in administrator taking effect.

§ 4610.6. Workers' Compensation and Insurance -- Medical and Hospital Treatment

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

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

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

(d) (1) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, and the determination shall be issued, as follows:

(A) For a dispute over medication prescribed pursuant to the drug formulary submitted under subdivision (h) of Section 4610.5, within five working days from the date of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(B) For all other medical treatment disputes submitted for review under subdivision (h) of Section 4610.5, within 30 days of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(C) If the disputed medical treatment has not been provided and the employee's provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information.

(2) Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

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

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

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

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

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

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

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

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

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

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

(j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision (l) is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars ($5,000) for each day the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

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

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

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

§ 4611. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(b) For purposes of this section, the following terms have the following meanings:

(1) "Contracting agent" has the meaning set forth in paragraph (2) of subdivision (d) of Section 4609.

(2) "Payor" has the meaning set forth in paragraph (3) of subdivision (d) of Section 4609.

§ 4614. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) (1) Notwithstanding Section 5307.1, where the employee's individual or organizational provider of health care services rendered under this division and paid on a fee-for-service basis is also the provider of health care services under contract with the employee's health benefit program, and the service or treatment provided is included within the range of benefits of the employee's health benefit program, and paid on a fee-for-service basis, the amount of payment for services provided under this division, for a work-related occurrence or illness, shall be no more than the amount that would have been paid for the same services under the health benefit plan, for a non-work-related occurrence or illness.

(2) A health care service plan that arranges for health care services to be rendered to an employee under this division under a contract, and which is also the employee's organizational provider for nonoccupational injuries and illnesses, with the exception of a nonprofit health care service plan that exclusively contracts with a medical group to provide or arrange for medical services to its enrollees in a designated geographic area, shall be paid by the employer for services rendered under this division only on a capitated basis.

(b) (1) Where the employee's individual or organizational provider of health care services rendered under this division who is not providing services under a contract is not the provider of health care services under contract with the employee's health benefit program or where the services rendered under this division are not within the benefits provided under the employer-sponsored health benefit program, the provider shall receive payment that is no more than the average of the payment that would have been paid by five of the largest preferred provider organizations by geographic region. Physicians, as defined in Section 3209.3, shall be reimbursed at the same averaged rates, regardless of licensure, for the delivery of services under the same procedure code. This subdivision shall not apply to a health care service plan that provides its services on a capitated basis.

(2) The administrative director shall identify the regions and the five largest carriers in each region. The carriers shall provide the necessary information to the administrative director in the form and manner requested by the administrative director. The administrative director shall make this information available to the affected providers on an annual basis.

(c) Nothing in this section shall prohibit an individual or organizational health care provider from being paid fees different from those set forth in the official medical fee schedule by an employer, insurance carrier, third-party administrator on behalf of employers, or preferred provider organization representing an employer or insurance carrier provided that the administrative director has determined that the alternative negotiated rates between the organizational or individual provider and a payer, a third-party administrator on behalf of employers, or a preferred provider organization will produce greater savings in the aggregate than if each item on billings were to be charged at the scheduled rate.

(d) For the purposes of this section, "organizational provider" means an entity that arranges for health care services to be rendered directly by individual caregivers. An organizational provider may be a health care service plan, disability insurer, health care organization, preferred provider organization, or workers' compensation insurer arranging for care through a managed care network or on a fee-for-service basis. An individual provider is either an individual or institution that provides care directly to the injured worker.

§ 4614.1. Workers' Compensation and Insurance -- Medical and Hospital Treatment

Notwithstanding subdivision (f) of Section 1345 of the Health and Safety Code, a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act and certified by the administrative director pursuant to Section 4600.5 to provide health care pursuant to Section 4600.3 shall be permitted to accept payment from a self-insured employer, a group of self-insured employers, or the insurer of an employer on a fee-for-service basis for the provision of such health care as long as the health care service plan is not both the health care organization in which the employee is enrolled and the plan through which the employee receives regular health benefits.

§ 4615. Workers' Compensation and Insurance -- Medical and Hospital Treatment

(a) Upon the filing of criminal charges against a physician, practitioner, or provider for any crime described in subparagraph (A) of paragraph (1) of subdivision (a) of Section 139.21, the following shall occur:

(1) Any lien filed by, or on behalf of, the physician, practitioner, or provider or any entity controlled, as defined in paragraph (3) of subdivision (a) of Section 139.21, by the physician, practitioner, or provider for medical treatment services under Section 4600 or medical-legal services under Section 4621, and any accrual of interest related to the lien, shall be automatically stayed.

(2) Except as provided in subdivisions (b) and (c), the stay shall be in effect from the time of the filing of the charges until the disposition of the criminal proceedings.

(b) Upon conviction, as defined in paragraph (4) of subdivision (a) of Section 139.21, of the physician, practitioner, or provider for any crime described in subparagraph (A) of paragraph (1) of subdivision (a) of Section 139.21, the automatic stay shall remain in effect for any liens not dismissed pursuant to paragraph (1) of subdivision (e) of Section 139.21 until the commencement of lien consolidation procedures under paragraph (2) of subdivision (e) of Section 139.21.

(c) The automatic stay required by this section shall not preclude a physician, practitioner, or provider from requesting the dismissal with prejudice and forfeiture of sums claimed therein of any liens subject to the stay. Upon the receipt of that request and for good cause shown, the chief judge of the Division of Workers Compensation or his or her designee may lift the stay as to one or more of those liens and order that they be dismissed with prejudice.

(d) The administrative director shall promptly post on the division's Internet Web site the names of any physician, practitioner, or provider of medical treatment services whose liens are stayed pursuant to this section.

(e) The automatic stay required by this section shall not preclude the appeals board from inquiring into and determining within a workers' compensation proceeding whether a lien is stayed pursuant to subdivision (a) or whether a lien claimant is controlled by a physician, practitioner, or provider.

(f) The administrative director may adopt rules for the implementation of this section.

(g) Notwithstanding this section, the filing of new or additional criminal charges against a physician, practitioner, or provider who has been suspended pursuant to subparagraph (A) of paragraph (1) of subdivision (a) of Section 139.21 shall not stay liens that are subject to consolidation and adjudication pursuant to subdivisions (e) to (i), inclusive, of Section 139.21, unless a determination has been made pursuant to subdivision (i) of Section 139.21 that a lien did not arise from the conduct that subjected the physician, practitioner, or provider to suspension.