

***COMPILATION OF
CHANGES IN THE
WORKERS' COMPENSATION LAWS***

***EFFECTIVE AS OF
JANUARY 1, 2001
(Unless Otherwise Stipulated)***

***Compiled By
Nancy P. Fox***

TABLE OF CONTENTS

<u>SUBJECT</u>	<u>PAGE NO.</u>
BUSINESS AND PROFESSIONS CODE	
§511.1 <i>Sale, Lease, Transfer of List of Contracted Health Care Providers and Reimbursement Rates; Disclosures and Other Requirements</i>	1
HEALTH AND SAFETY CODE	
§1395.6 <i>Sale, Lease, Transfer of List of Contracted Health Care Providers and Reimbursement Rates; Disclosures and Other Requirements</i>	5
INSURANCE CODE:	
§10178.3 <i>Sale, Lease, Transfer of List of Contracted Health Care Providers and Reimbursement Rates; Disclosures and Other Requirements</i>	9
§11664 <i>Nonrenewal Notices; Requirements; Policy Continuation for Failure of Time Notice; Exceptions</i>	13
§11750 <i>Purpose of Article</i>	15
LABOR CODE:	
§138.6 <i>Workers' Compensation Information System, Development of</i>	16
§139.2 <i>Appointment, Qualification, Suspension, Termination of QME's; Timeframes, Guidelines, Procedures, and Admissibility of Medical Evaluations</i>	17
§3212.1 <i>Cancer Presumption; Active Firefighters and Peace Officers</i>	25
§3212.8 <i>Hepatitis; Active Firefighters and Peace Officers</i>	26
§3212.9 <i>Meningitis; Active Firefighters and Peace Officers</i>	27
§4609 <i>Disclosures; Reimbursement Rates; Exclusion; Entitlement</i>	28
§4850 <i>Paid Leave of Absence for Specified Public Employees</i>	32
§5402 <i>Employer's Knowledge Equivalent to Notice; Employer's Notice to Employee or Employee's Dependents</i>	34

BUSINESS AND PROFESSIONS CODE SECTION 511.1

SALE, LEASE, TRANSFER OF LIST OF CONTRACTED HEALTH CARE PROVIDERS AND REIMBURSEMENT RATES; DISCLOSURES AND OTHER REQUIREMENTS

511.1. (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 a~~ 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 to the provider in advance and that the payor shall actively encourage ~~patients~~ beneficiaries 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 a payor's beneficiaries 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 its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor 's contract with subscribers or insureds offers ~~its~~ beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information directly to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, 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 beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or internet web site addresses supplied directly to every beneficiary. However, internet web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(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 payors' beneficiaries 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 payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

Business and Professions Code Sec. 511.1

(4) Disclose, upon the initial signing of a contract, and within 30 calendar 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.

~~Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.~~

~~(e) A contracting agent shall allow~~

(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 payors' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). ~~of subdivision (b).~~ Each provider's election under this ~~subdivision~~ **paragraph** shall be binding on ~~every~~ the contracting agent or payor that buys, leases, or otherwise obtains a **with which the provider has the contract and on any other contracting agent that buys, leases, or otherwise obtains the** contracted providers.

~~(d) 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 payors' beneficiaries 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 payors' beneficiaries to use the list of contracted providers when obtaining medical care.~~

(6) 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).

~~(e) A payor shall provide~~

(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 plan or 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.

~~(f) A payor shall demonstrate~~

(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 failure of a payor to ~~do so~~ **make the demonstration within 30 business days** shall render the payor liable **responsible** for the amount that the payor would have been required to pay pursuant to the contract between the payor and the beneficiary, which amount shall be due and payable within 10 **business** 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

Business and Professions Code Sec. 511.1

entitled to pay a contracted rate as provided in this ~~subdivision~~ **paragraph**. 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:

~~(1)~~

(A) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

~~(2)~~

(B) Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the list of contracted providers pursuant to **paragraph (5) of subdivision ~~(e)-(b)~~**.

~~(e)~~

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

(1) "Beneficiary" means:

(A) For workers' compensation **insurance**, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, ~~a named insured~~ **those persons covered under the medical payments portion of the insurance contract.**

(C) For group or individual health ~~care coverage~~ services **covered** through a health care service plan **contract, including a specialized health care service plan contract**, or a **policy of** disability ~~insurer~~ **insurance that covers hospital, medical, or surgical benefits**, a subscriber, **an enrollee, a policyholder**, or an insured.

(2) "Contracting agent" means ~~an individual or entity, including, but not limited to,~~ a third-party administrator or trust **not licensed under the Health and Safety Code, the Insurance Code, or the Labor Code, a self-insured employer**, a preferred provider organization, or an independent practice association, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, **or** conveying, ~~or arranging the availability of~~ a provider or provider panel to provide health care services to beneficiaries. For purposes of this section, a contracting agent shall not include a health care service plan, **including** a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability ~~life~~ **insurance that covers hospital, medical, or surgical benefits**, automobile insurance, or workers' compensation insurance, or a self-insured employer.

(3) ~~Except as otherwise provided in this paragraph, "payor" means a health care service plan, a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability, life, automobile, or workers' compensation insurance, a self-insured employer, a third party administrator or trust, or any other third party that is responsible to pay for health care services provided to~~

Business and Professions Code Sec. 511.1

~~beneficiaries. However, for purposes of subdivisions (e) and (f) a payor shall not include a health care service plan, a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability, life, automobile, or worker's compensation insurance, or a self-insured employer.~~

(A) For 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, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For purposes of subdivision (c), "payor" means only those entities that provide coverage for hospital, medical, or surgical benefits that are not regulated under the Health and Safety Code, the Insurance Code, or the Labor Code.

(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 this division.

(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.

~~(f)~~

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

(Amended by Stats. 2000, C. 1069 (S.B. 1732); effective January 1, 2001)

HEALTH AND SAFETY CODE SECTION 1395.6

SALE, LEASE, TRANSFER OF LIST OF CONTRACTED HEALTH CARE PROVIDERS AND REIMBURSEMENT RATES; DISCLOSURES AND OTHER REQUIREMENTS

1395.6. (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 a 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 to the provider in advance and ***that the payor*** shall actively encourage ~~patients~~ ***beneficiaries*** 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 to the provider 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 a payor's ~~subscribers~~ ***beneficiaries*** 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 its ~~subscribers~~ ***beneficiaries*** to use the list of contracted providers if one of the following occurs:

(A) The ~~payor~~ ***payor's contract with subscribers or insureds*** offers its ~~subscribers~~ ***beneficiaries*** direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to ~~subscribers~~ ***its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer***, 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 ~~subscribers~~ ***beneficiaries*** in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet web site addresses supplied directly to every ~~subscriber~~ ***beneficiary***. However, internet web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a ~~subscriber~~ ***beneficiary***.

(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 payors' ~~subscribers~~ ***beneficiaries*** 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 payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.***

Health and Safety Code Sec. 1395.6

(4) Disclose, upon the initial signing of a contract, and within 30 calendar 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 agreement with any contracting agent. ~~Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's subscribers to use the list of contracted providers when obtaining medical care in the case of an emergency.~~

~~(e) A contracting agent shall allow~~

(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 payors' subscribers **beneficiaries** to use the list of contracted providers when obtaining medical care as described in paragraph (2). ~~of subdivision (b).~~ Each provider's election under this ~~subdivision~~ **paragraph** shall be binding on ~~every~~ the contracting agent or payor that buys, leases, or otherwise obtains a **with which the provider has the contract and any contracting agent that buys, leases, or otherwise obtains the** list of contracted providers.

~~(d)~~ A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, conveyed to payors that actively encourage the payors' subscribers **beneficiaries** 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 payors' subscribers **beneficiaries** to use the list of contracted providers when obtaining medical care.

~~(e) A payor shall provide~~

(6) 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 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.

~~(f) A payor shall demonstrate~~

(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 failure of a payor to ~~do so~~ **make the demonstration within 30 business days** shall render the payor **liable responsible** for the amount that the payor would have been required to pay pursuant to the applicable health care service plan contract, **including a specialized health care service plan contract**, covering the ~~enrollee~~ **beneficiary**, which amount shall be due and payable within 10 **business** 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~~ **paragraph**. 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:

Health and Safety Code Sec. 1395.6

~~(1)~~

~~(A)~~ Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

~~(2)~~

~~(B)~~ Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the list of contracted providers pursuant to paragraph (5) of subdivision ~~(e)~~ (b).

~~(e)~~

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

(1) "Beneficiary" means:

(A) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(2) "Contracting agent" means a health care service plan ~~or, including~~ a specialized health care service plan, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying, ~~or arranging the availability of~~ a provider or provider panel to payors to provide health care services to ~~subscribers~~ beneficiaries.

(3) "Payor" means a health care service plan or a specialized health care service plan. **(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, 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 only a health care service plan, including a specialized health care service plan that has purchased, leased, or otherwise obtained the use of a provider or provider panel to provide health care services to beneficiaries pursuant to a contract that authorizes payment at discounted rates.

(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.

Health and Safety Code Sec. 1395.6

(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.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200).

(E) Any entity exempt from licensure pursuant to Section 1206.

⊕

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

(Amended by Stats. 2000, C. 1069 (S.B. 1732); effective January 1, 2001)

INSURANCE CODE SECTION 10178.3

SALE, LEASE, OR TRANSFER OF LIST OF CONTRACTED HEALTH CARE PROVIDERS AND THEIR REIMBURSEMENT RATES; DISCLOSURES AND OTHER REQUIREMENTS

10178.3. (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~~ **a** 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 to the provider in advance and **that the payor** shall actively encourage ~~patients~~ **beneficiaries** 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 a payor's beneficiaries 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 its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor's **contract with subscribers or insureds** offers ~~its~~ beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to **its** beneficiaries, **who are parties to the contract, or, in the case of workers' compensation insurance, the employer**, 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 beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or internet web site addresses supplied directly to every beneficiary. However, internet web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(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 payors' beneficiaries 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 payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.**

Insurance Code Sec. 10178.3

(4) Disclose, upon the initial signing of a contract, and within 30 calendar 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. ~~Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.~~

~~(e) A contracting agent shall allow~~

~~(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 payors' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). ~~of subdivision (b).~~ Each provider's election under this subdivision **paragraph** shall be binding on ~~every~~ **the** contracting agent ~~or payor that buys, leases, or otherwise obtains a~~ with **which the provider has a contract and any other contracting agent that buys, leases, or otherwise obtains the** list of contracted providers.

~~(d)~~ 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 payors' beneficiaries 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 payors' beneficiaries to use the list of contracted providers when obtaining medical care.

~~(e) A payor shall provide~~

(6) 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 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.

~~(f) A payor shall demonstrate~~

(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 failure of a payor to ~~do so~~ **make the demonstration within 30 business days** shall render the payor ~~liable~~ **responsible** for the amount that the payor would have been required to pay pursuant to the beneficiary's policy with the payor, which amount shall be due and payable within 10 **business** 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:

~~(+)~~

Insurance Code Sec. 10178.3

~~(A)~~ Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

~~(2)~~

~~(B)~~ Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the list of contracted providers pursuant to paragraph (5) of subdivision (e)(b).

~~(e)~~

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

(1) "Beneficiary" means:

(A) For automobile insurance, ~~a named insured~~ those persons covered under the medical payments portion of the insurance contract.

(B) For group or individual health care coverage ~~services covered~~ through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurer insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(C) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(2) "Contracting agent" means ~~a self-insured employer or an insurer licensed under this code to provide disability~~ insurance that covers hospital, medical, or surgical benefits, life, automobile insurance, or workers' compensation insurance, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying or arranging the availability a provider or provider panel to provide health care services to beneficiaries.

(3) "Payor" means ~~a self-insured employer or an insurer licensed under this code to provide disability, life, automobile, or workers' compensation insurance, that is responsible to pay for health care services provided to beneficiaries.~~ (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 this 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 only an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, if that insurer is responsible to pay for health care services provided to beneficiaries.

(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.

Insurance Code Sec. 10178.3

(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.

(f)

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

(Amended by Stats. 2000, C. 1069 (S.B. 1732); Effective January 1, 2001)

INSURANCE CODE SECTION 11664

NONRENEWAL NOTICES; REQUIREMENTS; POLICY CONTINUATION FOR FAILURE OF TIMELY NOTICE; EXCEPTIONS

11664. (a) This section applies only to policies of workers' compensation insurance.

(b) A notice of nonrenewal shall be in writing and shall be delivered or mailed to the producer of record and to the named insured at the mailing address shown on the policy. Subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed.

(c) An insurer, at least 30 days, but not more than 120 days, in advance of the end of the policy period, shall give notice of nonrenewal, and the reasons for the nonrenewal, if the insurer intends not to renew the policy.

(d) If an insurer fails to give timely notice required by subdivision (c), the policy of insurance shall be continued, with no change in its premium rate, for a period of 60 days after the insurer gives the notice.

(e) A notice of nonrenewal shall not be required in any of the following situations:

(1) The transfer of, or renewal of, a policy without a change in its terms or conditions or the rate on which the premium is based between insurers that are members of the same insurance group.

(2) The policy has been extended for 90 days or less, if the notice required in subdivision (c) has been given prior to the extension.

(3) The named insured has obtained replacement coverage or has agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

(4) The policy is for a period of no more than 60 days and the insured is notified at the time of issuance that it may not be renewed.

(5) The named insured requests a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

(6) The insurer has made a written offer to the insured to renew the policy at a premium rate increase of less than 25 percent.

(A) If the premium rate in the governing classification for the insured is to be increased 25 percent or greater and the insurer intends to renew the policy, the insurer shall provide a written notice of a renewal offer not less than 30 days prior to the policy renewal date. The governing classification shall be determined by the rules and regulations established in accordance with subdivision (c) of Section 11750.3.

(B) For purposes of this section, "premium rate" means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

Insurance Code Sec. 11664

(f) After an insured has received a notice of nonrenewal, upon receiving a written request from the insured or the agent or broker of record on the nonrenewed policy, an insurer shall provide a premium and loss history report for the account's tenure or the past three years, whichever is shorter, plus loss experience during the current policy year, within 10 business days of receiving the request.

(Amended by C. 884 (A.B. 2297) Effective September 29, 2000)

INSURANCE CODE SECTION 11750

PURPOSE OF ARTICLE

11750. (a) The purpose of this article is to promote the public welfare by regulating concert of action between insurers in collecting and tabulating rating information and other data that may be helpful in the making of adequate pure premium rates for workers' compensation insurance and for employers liability insurance incidental thereto and written in connection therewith for all admitted insurers and in submitting them to the commissioner for approval; to authorize and regulate the existence and cooperation of qualified rating organizations to one of which each workers' compensation insurer shall belong; to authorize and regulate cooperation between insurers, rating organizations and advisory organizations in ratemaking and other related matters to the end that the purposes of this chapter may be complied with and carried into effect.

(b) Notwithstanding any other provision of law, within 60 days of receiving an advisory pure premium rate filing made pursuant to subdivision (b) of Section 11750.3, the Insurance Commissioner shall hold a public hearing, and within 30 days of the conclusion of the hearing, approve, disapprove, or modify the proposed rate.

(Amended by C. 884 (A.B. 2297) Effective September 29, 2000)

LABOR CODE SECTION 138.6

DEVELOPMENT OF WORKERS' COMPENSATION INFORMATION SYSTEM

138.6. (a) The administrative director, in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, shall develop a cost-efficient workers' compensation information system, which shall be administered by the division. The administrative director shall adopt regulations specifying the data elements to be collected by electronic data interchange.

(b) The information system shall do the following:

- (1) Assist the department to manage the workers' compensation system in an effective and efficient manner.
- (2) Facilitate the evaluation of the efficiency and effectiveness of the benefit delivery system.
- (3) Assist in measuring how adequately the system indemnifies injured workers and their dependents.
- (4) Provide statistical data for research into specific aspects of the workers' compensation program.

(c) The data collected electronically shall be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. ~~The director shall issue a report on the development of the system, and recommendations for any necessary legislative action, no later than July 1, 1995, and shall, upon request, make the report available to the Governor, the Legislature, and the public.~~ **The administrative director may adopt regulations authorizing the use of other nationally recognized data transmission formats in addition to those set forth in the Electronic Data Interchange System for the transmission of data required pursuant to this section. The administrative director shall accept data transmissions in any authorized format. If the administrative director determines that any authorized data transmission format is not in general use by claims administrators, conflicts with the requirements of state or federal law, or is obsolete, the administrative director may adopt regulations eliminating that data transmission format from those authorized pursuant to this subdivision.**

(Amended by Stats. 2000, C. 318(S.B. 1785); effective January 1, 2001)

LABOR CODE SECTION 139.2

**APPOINTMENT, QUALIFICATION, SUSPENSION, TERMINATION OF QME's;
TIMEFRAMES, GUIDELINES, PROCEDURES, AND
ADMISSIBILITY OF MEDICAL EVALUATIONS**

139.2. (a) The Industrial Medical Council shall appoint qualified medical evaluators in each of the respective specialties as required for the evaluation of medical issues. The appointments shall be for two-year terms.

(b) The council shall appoint ***or reappoint*** as ***a*** qualified medical evaluators ~~a~~ physicians, as defined in Section 3209.3, who ~~is~~ ***are*** licensed to practice in this state and who demonstrate that ~~he or she~~ ***they*** meets ~~each of the following requirements:~~ ***the requirements in paragraphs (1), (2), (6) and (7), and if the physician is a medical doctor, doctor of osteopathy, doctor of chiropractic, or a psychologist, that he or she also meets the applicable requirements in paragraph (3), (4), or (5).***

(1) ***Prior to his or her appointment as a qualified medical evaluator, Pass passes*** an examination written and administered by the Industrial Medical Council for the purpose of demonstrating competence in evaluating medical-***legal*** issues in the workers' compensation system. ~~The council shall administer the first examination on or before July 1, 1994. Physicians qualified immediately before the first examination is administered shall pass an examination by November 1, 1994, to meet this requirement. Any physician applying for appointment after July 1, 1994, shall pass an examination prior to his or her appointment as a qualified medical evaluator. Physicians are not required to pass an additional examination for reappointment. For preparation of the first examination, a panel of not more than 40 experts, appointed by the Industrial Medical Council, representing the physician specialties required to take the qualified medical evaluator examination, shall assist the council in determining the knowledge, skills, and abilities required by the qualified medical evaluator, writing items for the examination, and conducting pretest and posttest reviews of the items. This panel of experts shall be exempt from the requirement of having to pass the examination to be appointed as a qualified medical evaluator. This panel of experts shall include: current or past council members, or both, representatives from the professional associations of those physician specialties required for the evaluation of medical issues, or physicians deemed to be well qualified in the evaluation of medical issues and having a minimum of 10 years in practice, five years of workers' compensation evaluation, and having served as an agreed medical evaluator at least eight times in the previous 12 months. Physicians shall not be required to pass an additional examination as a condition of reappointment. A physician seeking appointment as a qualified medical evaluator on or after January 1, 2001, shall also complete prior to appointment, a course on disability evaluation report writing approved by the Industrial Medical Council. The Industrial Medical Council shall specify the curriculum to be covered by disability evaluation report writing courses, which shall include, but is not limited to, 12 or more hours of instruction.~~

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

(3) Meet one of the following requirements:

Is board certified in a specialty by ~~an appropriate~~ ***a*** board recognized by the council: ***and either the Medical Board of California of the Osteopathic Medical Board of California.*** ~~For a physician with an~~

Labor Code Sec. 139.2

M.D. or D.O. degree, "board certified" means the physician is board certified by a specialty board recognized by the council and the Medical Board of California or the Osteopathic Medical Board of California.

~~(B) Is board qualified, as defined in this subparagraph, for a period not to exceed seven years from the time the physician first became board qualified under this subparagraph. For a physician with an M.D. or D.O. degree, "board qualified" means the physician has completed the minimum requirements as defined by a specialty board recognized by the council for postgraduate training in the specialty at an institution recognized by the American College of Graduate Medical Education or the osteopathic equivalent. Physicians who completed the minimum postgraduate training requirements in a specialty on or after January 1, 1990, and prior to January 1, 1995, shall have until January 1, 2003, to become board certified or to become otherwise eligible under this section. A physician whose board qualification status under this subparagraph in a particular specialty expires during his or her appointment as a qualified medical evaluator shall continue to serve but shall not be reappointed by the council in that specialty until he or she becomes board certified or becomes otherwise eligible under this section.~~

~~No physician who failed a specialty certification examination after 1985 shall be reappointed pursuant to this subparagraph as a qualified medical evaluator in that specialty until the physician subsequently passes the specialty certification examination.~~

~~(C) Declares under penalty of perjury to the council that he or she wrote 100 or more ratable comprehensive medical legal evaluation reports and served as an agreed medical evaluator on 25 or more occasions during each calendar year between January 1, 1990, and December 31, 1994.~~

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

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

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

~~(E) If a chiropractor, has either: (i) completed a~~

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

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

(B) Has been certified in California workers' compensation evaluation by ~~an appropriate California professional chiropractic association or accredited California college~~ **provider** recognized by the council. **The certification program shall include instruction on disability evaluation report writing that meets the standards set forth in paragraph (1).**

~~(F) If a psychologist,~~

Labor Code Sec. 139.2

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

~~(i)~~

~~(A)~~ Is board certified in clinical psychology by a board recognized by the council.

~~(ii)~~

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

~~(iii)~~

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

~~(G)~~ Served as an agreed medical evaluator on eight or more occasions prior to January 1, 1970.

~~(4)~~

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

~~(5)~~

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

(c) The council shall promulgate standards for appointment of physicians who are retired or who hold teaching positions who are exceptionally well qualified to serve as a qualified medical evaluator even though they do not otherwise qualify under paragraph (2) of subdivision (b). In no event shall a physician whose full-time practice is limited to the forensic evaluation of disability be appointed as a qualified medical evaluator under this subdivision.

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

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

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

Labor Code Sec. 139.2

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

(4) Has not been terminated, suspended, placed on probation, or otherwise disciplined by the council during his or her most recent term as a qualified medical evaluator. If the evaluator does not meet any one of these criteria, the Industrial Medical Council may in its discretion reappoint or deny reappointment according to regulations promulgated by the council. In no event may a physician who does not currently meet the requirements for initial appointment or who has been terminated under subdivision (e) because his or her license has been revoked or terminated by the licensing authority be reappointed.

(e) The council may, in its discretion, suspend or terminate a qualified medical evaluator during his or her term of appointment without a hearing as provided under subdivision (k) or (l) whenever:

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

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

(f) The Industrial Medical Council shall furnish a physician, upon request, a written statement of its reasons for termination of or for denying appointment or reappointment as a qualified medical evaluator. Upon receipt of a specific response to the statement of reasons, the Industrial Medical Council shall review its decision not to appoint or reappoint the physician or to terminate the physician and shall notify the physician of its final decision within 60 days after receipt of the physician's response.

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

(h) When the injured worker is not represented by an attorney, the medical director appointed pursuant to Section 122, shall assign three-member panels of qualified medical evaluators within five working days after receiving a request for a panel. If a panel is not assigned within 15 working days, the employee shall have the right to obtain a medical evaluation from any qualified medical evaluator of his or her choice. The medical director shall use a random selection method for assigning panels of qualified medical evaluators. The medical director shall select evaluators who are specialists of the type selected by the employee. The medical director shall advise the employee that he or she should consult with his or her treating physician prior to deciding which type of specialist to request. The Industrial Medical Council shall promulgate a form which shall notify the employee of the physicians selected for his or her panel. The form shall include, for each physician on the panel, the physician's name, address, telephone number, specialty, number of years in practice, and a brief description of his or her education and training, and shall advise the employee that he or she is entitled to receive transportation expenses and temporary disability for each day necessary for the examination. The form shall also state in a clear and conspicuous location and type: "You have the right to consult with an information and assistance officer at no cost to you prior to selecting the doctor to prepare your evaluation, or you may consult with an attorney. If your claim eventually goes to court, the judge will consider the evaluation prepared by the doctor you select to

Labor Code Sec. 139.2

decide your claim." When compiling the list of evaluators from which to select randomly, the medical director shall include all qualified medical evaluators who:

(1) do not have a conflict of interest in the case, as defined by regulations adopted pursuant to subdivision(o);

(2) are certified by the council to evaluate in an appropriate specialty and at locations within the general geographic area of the employee's residence; and,

(3) have not been suspended or terminated as a qualified medical evaluator for failure to pay the fee required by the council pursuant to subdivision (n) or for any other reason. When the medical director determines that an employee has requested an evaluation by a type of specialist which is appropriate for the employee's injury, but there are not enough qualified medical evaluators of that type within the general geographic area of the employee's residence to establish a three-member panel, the medical director shall include sufficient qualified medical evaluators from other geographic areas and the employer shall pay all necessary travel costs incurred in the event the employee selects an evaluator from another geographic area.

(i) The medical director appointed pursuant to Section 122, shall continuously review the quality of comprehensive medical evaluations and reports prepared by agreed and qualified medical evaluators and the timeliness with which evaluation reports are prepared and submitted. The review shall include, but not be limited to, a review of a random sample of reports submitted to the division, and a review of all reports alleged to be inaccurate or incomplete by a party to a case for which the evaluation was prepared. The medical director shall submit to the administrative director an annual report summarizing the results of the continuous review of medical evaluations and reports prepared by agreed and qualified medical evaluators and make recommendations for the improvement of the system of medical evaluations and determinations. (j) After public hearing pursuant to Section 5307.4, the council shall promulgate rules and regulations concerning the following medical issues:

(1) Standards governing the timeframes within which medical evaluations shall be prepared and submitted by agreed and qualified medical evaluators. Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure. The council shall develop regulations governing the provision of extensions of the 30-day period in cases:

(A) where the evaluator has not received test results or consulting physician's evaluations in time to meet the 30-day deadline; and,

(B) to extend the 30-day period by not more than 15 days when the failure to meet the 30-day deadline was for good cause. For purposes of this subdivision, "good cause" means:

(i) medical emergencies of the evaluator or evaluator's family;

(ii) death in the evaluator's family; or,

Labor Code Sec. 139.2

(iii) natural disasters or other community catastrophes that interrupt the operation of the evaluator's business. The council shall develop timeframes governing availability of qualified medical evaluators for unrepresented employees under Sections 4061 and 4062. These timeframes shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, but shall also permit the employee to waive this right for a specified period of time thereafter.

(2) Procedures to be followed by all physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury. In order to produce complete, accurate, uniform, and replicable evaluations, the procedures shall require that an evaluation of anatomical

loss, functional loss, and the presence of physical complaints be supported, to the extent feasible, by medical findings based on standardized examinations and testing techniques generally accepted by the medical community. (3) Procedures governing the determination of any disputed medical issues.

(4) Procedures to be used in determining the compensability of psychiatric injury. The procedures shall be in accordance with Section 3208.3 and shall require that the diagnosis of a mental disorder be expressed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

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

(A) A medical-legal evaluation that has not been defined and valued pursuant to Section 5307.6. However, the council may recommend guidelines for evaluations that have been defined and valued pursuant to Section 5307.6 for the purpose of governing the appointment, reappointment, and discipline of qualified medical evaluators. The guidelines shall establish minimum times for patient contact in the conduct of the evaluations, and shall be consistent with regulations adopted pursuant to Section 5307.6.

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

(C) Any other evaluation procedure requested by the administrative director, the Insurance Commissioner, or the council itself. If, without good cause, the council fails to adopt the guidelines required by subparagraph (A) or (B) by March 31, 1994, or fails, without good cause, to adopt a guideline pursuant to subparagraph (C) within six months after a request by the administrative director or the Insurance Commissioner, then the administrative director shall have the authority to adopt the guideline.

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

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

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

Labor Code Sec. 139.2

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

(3) Has failed to comply with the timeframe standards established by the council pursuant to subdivision (j). (4) Has failed to meet the requirements of subdivision (b) or (c).

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

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

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

(A) failed to timely pay the fee required by the council pursuant to subdivision (n); or,

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

(l) The council shall cite the qualified medical evaluator for a violation listed in subdivision (k) and shall set a hearing on the alleged violation within 30 days of service of the citation on the qualified medical evaluator. In addition to the authority to terminate or suspend the qualified medical evaluator upon finding a violation listed in subdivision (k), the council may, in its discretion, place a qualified medical evaluator on probation subject to appropriate conditions, including ordering continuing education or training. The council shall report to the appropriate licensing board the name of any qualified medical evaluator who is disciplined pursuant to this subdivision.

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

(n) Each qualified medical evaluator shall pay a fee, as determined by the Industrial Medical Council, for appointment or reappointment. Any qualified medical evaluator appointed prior to January 1, 1993, shall also pay the same fee as specified herein. These fees shall be based on a sliding scale as established by the council. All revenues from fees paid under this subdivision shall be deposited into the Industrial Medicine Fund, which is hereby created for the administration of the Industrial Medical Council. Moneys paid into the Industrial Medicine Fund for the activities of the Industrial Medical Council shall not be used by any other department or agency or for any purpose other than administration of the council. The

Labor Code Sec. 139.2

funds provided to the council from the Industrial Medicine Fund shall not supplant any funds appropriated to the council from the Workers' Compensation Administration Revolving Fund, the General Fund, or any other governmental source. Any future annual appropriation to the council from the Workers' Compensation Administration Revolving Fund, the General Fund, or any other governmental source shall not be less than the amount appropriated or provided during the 1991-92 fiscal year.

(o) An evaluator may not request or accept any compensation or other thing of value from any source that does or could create a conflict with his or her duties as an evaluator under this code. The administrative director, after consultation with the council and the Commission on Health and Safety and Workers' Compensation, shall adopt regulations to implement this subdivision on or before July 1, 1994.

(Amended by Stats. 200, C. 54 (A.B. 776); Effective January 1, 2001)

LABOR CODE SECTION 3212.1

CANCER PRESUMPTION; ACTIVE FIREFIGHTERS AND PEACE OFFICERS

3212.1. (a) This section applies to active firefighting members, whether volunteers, partly paid, or fully paid, of all of the following fire departments: (1) a fire department of a city, county, city and county, district, or other public or municipal corporation or political subdivision, (2) a fire department of the University of California and the California State University, (3) the Department of Forestry and Fire Protection, and (4) a county forestry or firefighting department or unit. This section also applies to peace officers, as defined in Section 830.1, ~~and~~ subdivision (a) of Section 830.2, ~~of the Penal Code~~ **and subdivisions (a) and (b) of Section 830.37, of the Penal Code,** who are primarily engaged in active law enforcement activities.

(b) The term "injury," as used in this division, includes cancer, including leukemia, that develops or manifests itself during a period in which any member described in subdivision (a) is in the service of the department or unit, if the member demonstrates that he or she was exposed, while in the service of the department or unit, to a known carcinogen as defined by the International Agency for Research on Cancer, or as defined by the director.

(c) The compensation that is awarded for cancer shall include full hospital, surgical, medical treatment, disability indemnity, and death benefits, as provided by this division.

(d) The cancer so developing or manifesting itself in these cases shall be presumed to arise out of and in the course of the employment. This presumption is disputable and may be controverted by evidence that the primary site of the cancer has been established and that the carcinogen to which the member has demonstrated exposure is not reasonably linked to the disabling cancer. Unless so controverted, the appeals board is bound to find in accordance with the presumption. This presumption shall be extended to a member following termination of service for a period of three calendar months for each full year of the requisite service, but not to exceed 60 months in any circumstance, commencing with the last date actually worked in the specified capacity.

(e) The amendments to this section enacted during **the 1999 portion of** the 1999-2000 Regular Session shall be applied to claims for benefits filed or pending on or after January 1, 1997, including, but not limited to, claims for benefits filed on or after that date that have previously been denied, or that are being appealed following denial.

(Amended by Stats. 2000, C. 887 (S.B. 1820); effective January 1, 2001)

LABOR CODE SECTION 3212.8

HEPATITIS; ACTIVE FIREFIGHTERS AND PEACE OFFICERS

3212.8. (a) In the case of members of a sheriff's office, of police or fire departments of cities, counties, cities and counties, districts, or other public or municipal corporations or political subdivisions, or individuals described in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, whether those persons are volunteer, partly paid, or fully paid, and in the case of active firefighting members of the Department of Forestry and Fire Protection, or of any county forestry or firefighting department or unit, whether voluntary, fully paid, or partly paid, excepting those whose principal duties are clerical or otherwise do not clearly fall within the scope of active law enforcement service or active firefighting services, such as stenographers, telephone operators, and other office workers, the term "injury" as used in this division, includes hepatitis when any part of the hepatitis develops or manifests itself during a period while that person is in the service of that office, staff, division, department, or unit. The compensation that is awarded for hepatitis shall include, but not be limited to, full hospital, surgical, medical treatment, disability indemnity, and death benefits, as provided by the workers' compensation laws of this state.

b) The hepatitis so developing or manifesting itself in those cases shall be presumed to arise out of and in the course of the employment or service. This presumption is disputable and may be controverted by other evidence, but unless so controverted, the appeals board is bound to find in accordance with it. That presumption shall be extended to a person covered by subdivision (a) following termination of service for a period of three calendar months for each full year of service, but not to exceed 60 months in any circumstance, commencing with the last date actually worked in the specified capacity.

(c) The hepatitis so developing or manifesting itself in those cases shall in no case be attributed to any disease existing prior to that development or manifestation.

(Added by Stats. 2000, C. 490 (S.B. 32); Effective January 1, 2001)

LABOR CODE SECTION 3212.9

MENINGITIS PRESUMPTION; ACTIVE FIREFIGHTERS AND PEACE OFFICERS

3212.9. In the case of a member of a police department of a city, county, or city and county, or a member of the sheriff's office of a county, or a county probation officer, or an inspector or investigator in a district attorney's office of any county whose principal duties consist of active law enforcement service, when that person is employed on a regular, full-time salary, or in the case of a member of a fire department of any city, county, or district, or other public or municipal corporation or political subdivision, or any county forestry or firefighting department or unit, when those members are employed on a regular full-time salary, excepting those whose principal duties are clerical or otherwise do not clearly fall within the scope of active law enforcement or firefighting, such as stenographers, telephone operators, and other officeworkers, the term "injury" includes meningitis that develops or manifests itself during a period while that person is in the service of that department, office, or unit. The compensation that is awarded for the meningitis shall include full hospital, surgical, medical treatment, disability indemnity, and death benefits as provided by the provisions of this division.

The meningitis so developing or manifesting itself shall be presumed to arise out of and in the course of the employment. This presumption is disputable and may be controverted by other evidence, but unless so controverted, the appeals board is bound to find in accordance with it. This presumption shall be extended to a person following termination of service for a period of three calendar months for each full year of the requisite service, but not to exceed 60 months in any circumstance, commencing with the last date actually worked in the specified capacity.

(Added by Stats. 2000, C. 883 (A.B. 2043); Effective January 1, 2001)

LABOR CODE SECTION 4609

DISCLOSURE RELATING TO HEALTH CARE PROVIDER'S PARTICIPATION IN NETWORK; DISCLOSURES BY CONTRACTING AGENT CONVEYING ITS LIST OF CONTRACTED HEALTH CARE PROVIDERS AND REIMBURSEMENT RATES; ELECTION BY PROVIDER TO BE EXCLUDED FROM LIST; DEMONSTRATION BY PAYOR OR ENTITLEMENT TO PAY CONTRACTED RATE

4609. (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 ~~patients~~ ***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 (e)***, 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 ~~beneficiaries~~ ***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 ~~beneficiaries~~ ***employees*** to use the list of contracted providers if the employer ~~of the beneficiaries~~ provides information directly to ~~beneficiaries~~ ***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 ~~beneficiaries~~ ***employees***; ***or*** in advance of ~~sustaining~~ a workplace injury, ***or upon notice of an injury or claim by an employee, which the*** approaches may include, but are not limited to, the use of provider directories, the use of a ~~posted~~ list of all contracted providers in an area geographically accessible to the posting site, the use of wall cards that direct ~~beneficiaries~~ ***employees*** to a readily accessible listing of those providers at the same location as the wall cards, the use of wall cards that direct ~~beneficiaries~~ ***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 ~~sub~~paragraph. Nothing in this ~~sub~~paragraph shall prevent contracting agents or ~~employers~~ ***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 ~~payors' beneficiaries~~ ***employees*** to use the list of contracted providers when obtaining medical care. ***Nothing in***

Labor Code Sec. 4609

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 ~~30 calendar~~ **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. ~~Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.~~

~~(c) A contracting agent shall allow~~

(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 ~~payors' beneficiaries~~ **employees** to use the list of contracted providers when obtaining medical care as described in paragraph (2). ~~of subdivision (b).~~ Each provider's election under this paragraph shall be binding on ~~every~~ **the** contracting agent ~~or payor~~ **with which the provider has the contract and any other contracting agent that** buys, leases, or otherwise obtains ~~a~~ **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 ~~payors' beneficiaries~~ **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 ~~payors' beneficiaries~~ **employees** to use the list of contracted providers when obtaining medical care.

~~(d) A~~

(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 (e).

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

Labor Code Sec. 4609

(1) ***Provide*** an explanation of benefits or explanation of review that identifies the name of the network ~~that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, with~~ ***which the payor has an agreement that entitles them*** to pay a preferred rate for the services rendered.

~~(f) A payor shall demonstrate~~

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 ~~do so~~ ***make the demonstration to a properly documented request of the provider within 30 business days*** shall render the payor ~~liable~~ ***responsible*** for the lesser of the provider's actual fee or, as applicable, ~~the official medical fee schedule, the official medical-legal fee schedule, or the in-patient fee schedule,~~ ***any fee schedule pursuant to 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:

~~(1) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes~~

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

~~(2)~~

(B) Identifies the ~~provider's written agreement with a contracting agent~~ ***with whom the payor has a written agreement*** whereby the ~~provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not~~ payor ***is not required to*** actively encourage beneficiaries ***employees*** to use the list of contracted providers pursuant to ***paragraph (5)*** of subdivision ~~(e)~~ ***(b).***

~~(g)~~

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

(1) ~~"Beneficiary" means an employee seeking health care services for a work-related injury.~~

~~(2) "Contracting agent" means a self-insured employer or 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, ~~or arranging the~~

Labor Code Sec. 4609

availability of a provider or provider panel to provide health care services to beneficiaries employees for work-related injuries.

~~(3) "Payor" means a self-insured employer or an insurer licensed under the Insurance Code to provide workers' compensation insurance.~~

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

(3) (A) For the purposes of subdivisions (b) and (c), "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 (d), "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 part 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.

~~(h)~~ **(f)** This section shall become operative on July 1, 2000.

(Amended by Stats. 2000, C. 1069 (S.B. 1732); effective January 1,2001)

LABOR CODE SECTION 4850

PAID LEAVE OF ABSENCE FOR SPECIFIED PUBLIC EMPLOYEES

4850. (a) Whenever any ~~city police officer, city, county, or district firefighter, sheriff or any officer or employee of a sheriff's office, any inspector, investigator, detective, or personnel with comparable title in any district attorney's office, any county probation officer, group counselor, or juvenile services officer, or any officer or employee of a probation office, any peace officer under Section 830.31 of the Penal Code employed on a regular, full-time basis by a county of the first class, or lifeguard employed year round on a regular, full-time basis by a county of the first class,~~ ***person listed in subdivision (b)*** who is a member of the Public Employees' Retirement System ***or the Los Angeles City Employees' Retirement System*** or subject to the County Employees Retirement Law of 1937 (Chapter 3 (commencing with Section 31450) of Part 3 of Division 4 of Title 3 of the Government Code), is disabled, whether temporarily or permanently, by injury or illness arising out of and in the course of his or her duties, he or she shall become entitled, regardless of his or her period of service with the city ~~or~~ county, ***or district***, to a leave of absence while so disabled without loss of salary in lieu of temporary disability payments or maintenance allowance payments under Section 139.5, if any, which would be payable under this chapter, for the period of the disability, but not exceeding one year, or until that earlier date as he or she is retired on permanent disability pension, and is actually receiving disability pension payments, or advanced disability pension payments pursuant to Section 4850.3.

(b) The persons eligible under subdivision (a) include all of the following:

- (1) City police officers.***
- (2) City, county, or district firefighters.***
- (3) Sheriffs.***
- (4) Officers or employees of any sheriff's offices.***
- (5) Inspectors, investigators, detectives, or personnel with comparable titles in any district attorney's office.***
- (6) County probation officers, group counselors, or juvenile services officers.***
- (7) Officers or employees of a probation office.***
- (8) Peace officers under Section 830.31 of the Penal Code employed on a regular, full-time basis by a county of*
the first class.**
- (9) Lifeguards employed year round on a regular, full-time basis by a county of the first class.***
- (10) Airport law enforcement officers under subdivision (d) of Section 830.33 of the Penal Code.***
- (11) Harbor or port police officers, wardens, or special officers of a harbor or port district or city or county*
***harbor department under subdivision (a) of Section 830.1 or subdivision (b) of Section 830.33 of the Penal*
Code.****
- (12) Police officers of the Los Angeles Unified School District.***

(b) (c) This section shall apply only to ~~city police officers, sheriffs or any officer or employee of a sheriff's office, and any inspector, investigator, detective, or personnel with comparable title in any district attorney's office, or any county probation officer, group counselor, or juvenile services officer or any officer, or employee of a probation office, who are members of the Public Employees' Retirement Section 31450) of Part 3 of Division 4 of Title 3 of the Government Code) and excludes employees~~

persons listed in subdivision (b) who meet the requirements of subdivision (a) and does not include any of the following:

(1) Employees of a police department whose principal duties are those of a telephone operator, clerk, stenographer, machinist, mechanic, or otherwise, and whose functions do not clearly fall within the scope of active law enforcement service, ~~and excludes employees~~

(2) Employees of a county sheriff's office whose principal duties are those of a telephone operator, clerk, stenographer, machinist, mechanic, or otherwise, and whose functions do not clearly come within the scope of active law enforcement service. ~~It also excludes employees~~

(3) Employees of a county probation office whose principal duties are those of a telephone operator, clerk, stenographer, machinist, mechanic, or otherwise, and whose functions do not clearly come within the scope of active law enforcement service. ~~It shall also apply to city, county, or district firefighters who are members of the Public Employees' Retirement System or subject to the County Employees Retirement Law of 1937 (Chapter 3 (commencing with Section 31450) of Part 3 of Division 4 of Title 3 of the Government Code) and excludes employees~~

(4) Employees of ~~the a~~ city fire department, county fire department, ~~and of any~~ or fire district whose principal duties are those of a telephone operator, clerk, stenographer, machinist, mechanic, or otherwise, and whose functions do not clearly fall within the scope of active firefighting and prevention service. ~~It shall also apply to deputy sheriffs, and to peace officers under Section 830.31 of the Penal Code employed on a regular, full time basis by a county of the first class, who are subject to the County Employees Retirement Law of 1937 (Chapter 3 (commencing with Section 31450) of Part 3 of Division 4 of Title 3 of the Government Code). It shall also apply to probation officers, group counselors, juvenile service officers, or any officer or employee of a probation office, subject to the County Employees Retirement Law of 1937 (Chapter 3 (commencing with Section 31450) of Part 3 of Division 4 of Title 3 of the Government Code). It shall also apply to lifeguards employed year round on a regular, full time basis by a county of the first class who are subject to the County Employees Retirement Law of 1937 (Chapter 3 (commencing with Section 31450) of Part 3 of Division 4 of Title 3 of the Government Code).~~

~~(e)~~ (d) If the employer is insured, the payments which, except for this section, the insurer would be obligated to make as disability indemnity to the injured, the insurer may pay to the insured.

~~(d)~~ (e) No leave of absence taken pursuant to this section by a peace officer, as defined by Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, shall be deemed to constitute family care and medical leave, as defined in Section 12945.2 of the Government Code, or to reduce the time authorized for family care and medical leave by Section 12945.2 of the Government Code.

(Amended by Stats. 200, C. 920 (A.B. 1883) and C. 929 (S.B. 2081); effective January 1, 2001)

LABOR CODE SECTION 5402

**EMPLOYER'S KNOWLEDGE EQUIVALENT TO NOTICE;
EMPLOYER'S NOTICE TO EMPLOYEE OR EMPLOYEE'S DEPENDENTS**

5402. **(a)** Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.

(b) If liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period.

(Amended by Stats. 2000, C. 883 (A.B. 2043); Effective January 1, 2001)